U.S. NAVY MEDICINE

September 1978

POLICY: *U.S. Navy Medicine* is an official publication of the Navy Medical Department, published by the Bureau of Medicine and Surgery. It disseminates to Navy Medical Department personnel official and professional information relative to medicine, dentistry, and the allied health sciences. Opinions expressed are those of the authors and do not necessarily represent the official position of the Department of the Navy, the Bureau of Medicine and Surgery, or any other governmental department or agency. Trade names are used for identification only and do not represent an endorsement by the Department of the Navy or the Bureau of Medicine and Surgery. Although *U.S. Navy Medicine* may cite or extract from directives, official authority for action should be obtained from the cited reference.

DISTRIBUTION: *U.S. Navy Medicine* is distributed to active-duty Medical Department personnel via the Standard Navy Distribution List. The following distribution is authorized: one copy for each Medical, Dental, Medical Service and Nurse Corps officer; one copy for every 10 enlisted Medical Department members. Requests to increase or decrease the number of allotted copies should be forwarded to *U.S. Navy Medicine* via the local command.

CORRESPONDENCE: All correspondence should be addressed to: Editor, *U.S. Navy Medicine*, Department of the Navy, Bureau of Medicine and Surgery (Code 0010), Washington, D.C. 20372. Telephone: (Area Code 202) 254-4253, 254-4316, 254-4214; Autovon 294-4253, 294-4316, 294-4214. Contributions from the field are welcome and will be published as space permits, subject to editing and possible abridgment.

The issuance of this publication is approved in accordance with Department of the Navy Publications and Printing Regulations (NAVEXOS P-35).

NAVMED P-5088

U.S. NAVY MEDICINE

Vol. 69, No. 9
September 1978

COVER: Disabling illness, such as "stroke," is a "personal crisis for the patient—and a crisis for the whole family," says Ms. Lala Johnson, Chief of Social Work Service, NNMC Bethesda. In cooperation with NNMC's Neurological Service, she has begun a unique group therapy program for "caretakers" of disabled patients (see page 2). Photo reprinted by permission of the American Heart Association.

'I Am a Patient'

The following—written by CDR Joseph Smyth (MC)—was sent to me from Yokosuka. It so impressed me that I wish to insert it instead of my own letter to you this month.

You've seen me a hundred times—with many faces, many forms, many reasons for being in your care.

I am the frightened, middle-aged sailor, waiting at your admitting desk, nervously opening and closing my wallet.

I am the shuffling, stoop-shouldered figure in faded blue pajamas you encounter at every corner as you go about your daily work.

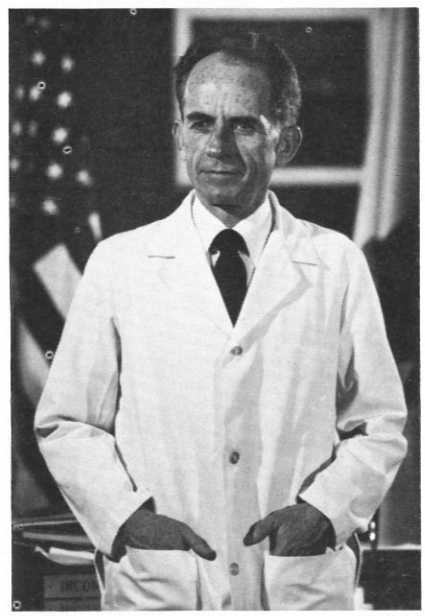
Everything is new and strange to me. Yesterday I was in familiar surroundings and happy, planning my tomorrows. Today I am in an alien world, trying hard to adjust. The little familiar things of my own world seem to take on great importance. I may complain to you. I may rebel against the strangeness. You see, I don't want to be in the hospital; I want to go back to my ship.

From the moment I walk up to your admitting desk, I am a mass of fears; I am fearful of the unknown. I am alarmed over the prospect of pain, disfigurement—even death. I fear financial distress or catastrophe. More than anything else, I am lonely.

If I tell you my coffee is cold, it may be because coffee is more than a breakfast drink to me. . . . Through years of experience I have come to associate it with congeniality, friendship, the warmth and security of shipmates. . . . [C]old coffee reminds me that I am among strangers, antiseptic and somehow frightening strangers.

When I object to early morning awaking, I often mean that I am insecure. When I report that my nurse or doctor is indifferent, I often mean I feel forsaken.

Please understand that often, in my complaints about little things, I am trying to tell you of far deeper needs. Will I lose my identity? Will I be exposed to all . . . sorts of indignities?



VADM Arentzen

I'm afraid that I'll be treated, not as a sailor, but as a "fascinating gall bladder," an "interesting thyroid." I appear normal, but I have left normalcy outside your door. Though I am mature, I have suddenly become a child, frightened of the long, dark nights. And, oh, how I want you to be warm and friendly! . . .

You may tell me that . . . some "discomforts," some "fears" are part of any hospital stay. I will tell you that I understand this perfectly when I am not a patient, but from the minute I enter your hospital, my outlook changes. Minor things take on abnormal importance.

Much of my fright . . . comes from lack of understanding on my part. All too often you take for granted that I know these things, and I'm left to grope for my answers alone. . . .

Help me bridge my initial feelings of embarrassment. Assure me that the bedpan is only temporary and that as I improve I'll be able to look after myself to a greater degree. Assure me that I am never alone or abandoned, even on the busiest hospital day. Reassure me that my struggle is not a private one—that my feelings, frustrations, resentments, and emotions are simply a part of being a patient.

Never forget, you've been a symbol to people like me ever since the Samaritan traveled the road between Jerusalem and Jericho two thousand years ago. The equipment and the methods have changed. But the concept continues unchanged.

You're the benevolent healer. You cannot—you dare not—change!

W.P. ARENTZEN
Vice Admiral, Medical Corps
United States Navy

At NNMC Bethesda, group therapy for 'caretakers' of disabled patients puts a . . .

Focus on the Family

"You do everything to help the patients. Why don't you do something to help the *families?*"

For Ms. Lala Johnson, who heads the Social Work Service at the National Naval Medical Center, Bethesda, Md., this anguished outburst hit home with special force. She herself, like the woman who confronted her, had had a close family member disabled by crippling "stroke."

"That's an excellent idea," she responded. "Can you identify enough families with similar problems so that we could start a group?"

Thus, two years ago, she launched a unique program of group therapy for family members who are "caretakers" of patients with chronic, disabling disorders.

The Bethesda group is the first of its kind to be formed at a Navy medical facility—and perhaps the first anywhere. Most of its current members are spouses of patients who have been discharged from the NNMC Neurology Service and are disabled, to varying degrees, by such disorders as stroke, dementia, and multiple sclerosis.

The range of disabilities with which these patients and their families must cope includes hemiplegia, hemiparesis, aphasia, loss of bladder and bowel control, and loss of mental function. For most of the patients, regression is inevitable.

Photos reprinted by permission of the American Heart Association.

In the hospital, trained personnel and special facilities are available . . .

One member summed up the purposes of NNMC's family group as follows:

"to maintain our mental health;

"to share our experiences so as to help others;

"to try to obtain some interest in the way of facilities or help for those afflicted."

The group, small enough so that members can draw their chairs into an informal circle, meets weekly at NNMC for about an hour and a half.

Ms. Johnson—a slight, soft-spoken woman with a warming smile—provides unobtrusive leadership: suggesting here, softly probing there, nudging the talk along when expression of feelings becomes difficult, and gently but firmly insisting on confrontation of painful issues. LCDR E. Wayne Massey, MC, USNR—a young neurologist who, like Johnson, has had experience with stroke in his own family—serves as co-leader and as a resource on medical queries.

Above all, the group furnishes a supportive atmosphere in which members can express, and begin to deal with, the devastating emotions generated in them by a world that illness has turned upside down.

There's a profound sense of sharing here—not only of feelings, but of constructive, practical ideas traded among people who deal with similar problems. No visitor to the group can fail to be impressed by its members' sharp humor, gallantry, vitality, and real strength.

A primary emotion ventilated in the group is grief.

One husband of a woman with a progressive neurological disorder expressed his continuing sense of mourning and loss as—from week to week, from month to month—his wife loses more of her ability to function. "It has just become too much to bear," he said, "too much to bear."

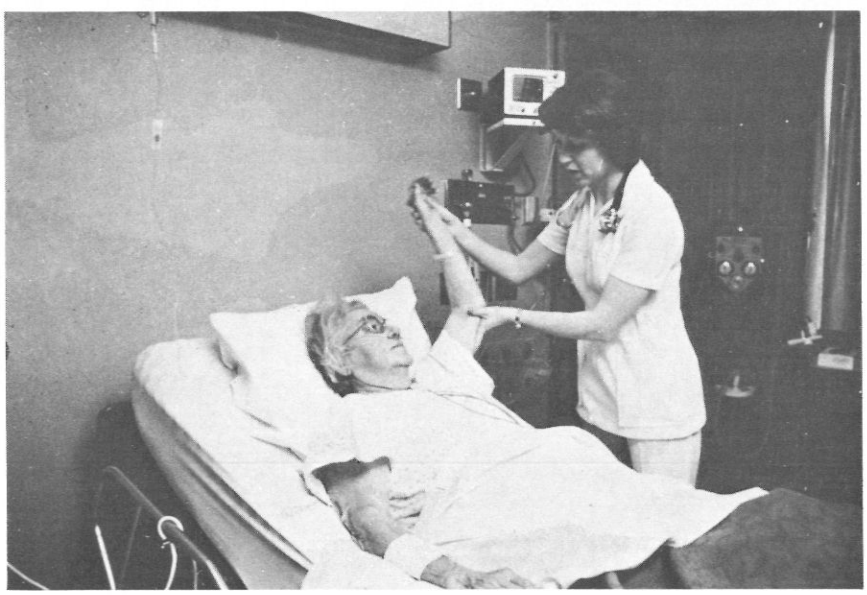
Others speak of their loneliness—of the deprivation of companionship from formerly close spouses whose mental function is now impaired: "The hardest thing is that there's no one to talk to" . . . "She's there, but she's not there."

What these families are mourning, Johnson points out, is really a kind of death—a death of part of the patient's body—and the disruption of close relationships that inevitably results. Indeed, she says, family members seem to go through stages similar to those described by Kübler-Ross in her now classic book *On Death and Dying*—with one exception. While the stages of denial, anger, and depression are frequently seen, the final stage eludes attainment.

"I thought the members would work through their feelings, reach the stage of acceptance, and leave the group," Johnson says, "but so far that just hasn't happened. I don't think they ever really reach acceptance."

"No one who hasn't been through this experience can ever really understand what it's like," says one group member—a sentiment echoed by all. For the caretaker in these situations is on duty 24 hours a day: cleaning house; providing the patient's meals on time; feeding, bathing, clothing, and grooming those who can't perform these functions unassisted (or at all); cleaning up after the incontinent; helping the ambulatory patient get around; in the case of some patients, simply *being* there, in every spare moment, hoping for some glimmer of recognition or response.

What most of us think of as simple matters—dressing, and such grooming tasks as clipping fingernails and toenails—may take the caretaker hours to accomplish for a patient who is unable to cooperate. If the patient is incontinent and unable to communicate, the caretaker tries desperately to anticipate needs, and thus avert accidents. In



. . . but after discharge, care will take place at home.

some cases, patients may be ambulatory but incontinent; thus, every outing must be carefully planned to keep the patient always within close range of a toilet. In cases of dementia, the caretaker may fear leaving the house long enough to go to the corner store: a patient who smokes, left alone, could burn the house down.

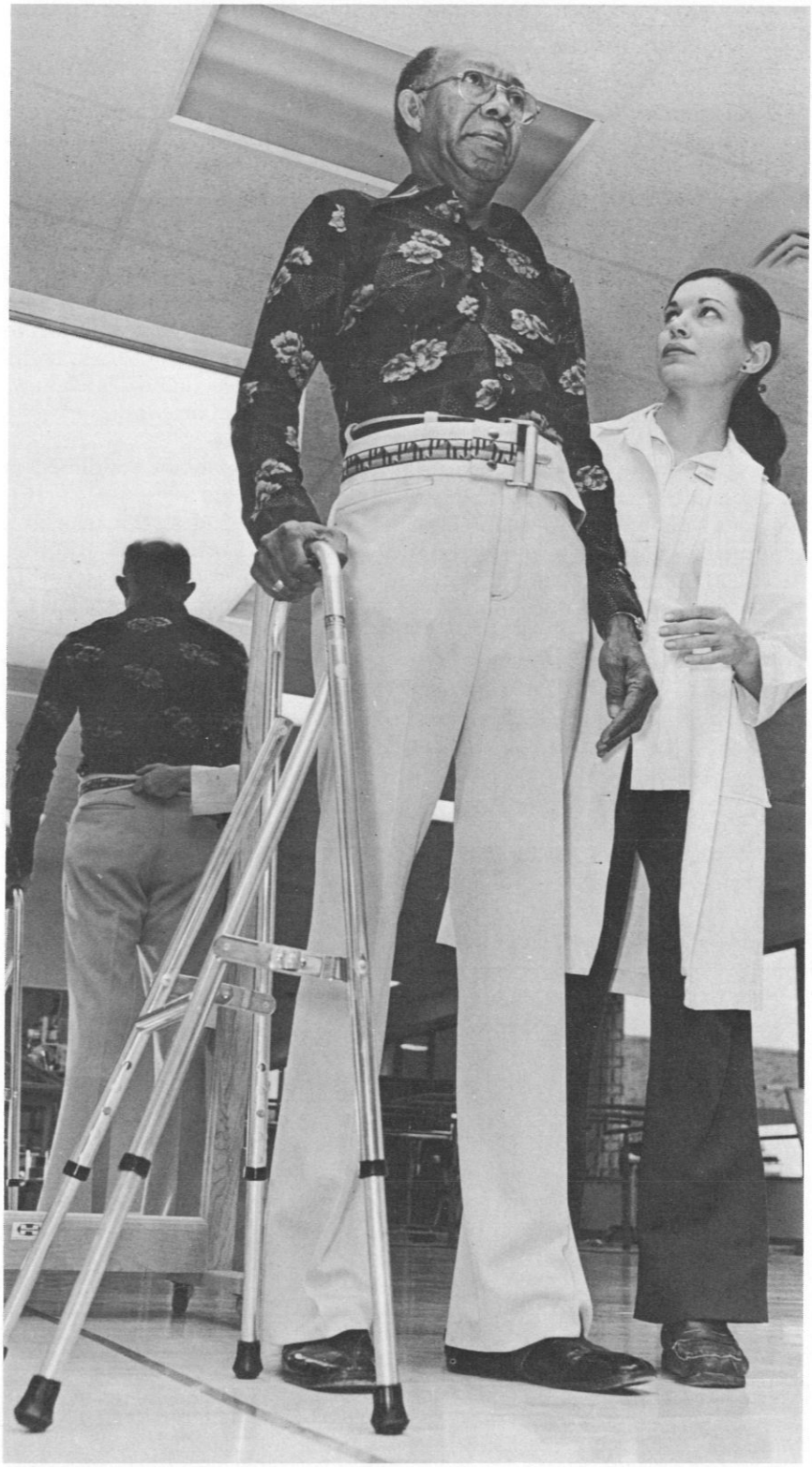
Of his two years with the group, Dr. Massey says: "One thing I've realized more and more is how restrictive this situation is for the patient's spouse." All too frequently, relatives or friends who could help, by staying with the patient long enough to give the caretaker a brief respite, withdraw from the scene, murmuring excuses: "I just can't stand to see him (her) that way . . ."

In a very real sense, Ms. Johnson points out, the caretaker is a captive. He or she, no matter how loving, is caught in a no-exit bind that elicits frustration, anger, and a desire to escape—emotions closely followed by overwhelming guilt.

"Is it normal to have these feelings?" one caretaker asked. An important function of the group is to assure members that these feelings are indeed most "normal," as are some even more difficult to express.

When, as in some cases, a family member can anticipate perhaps 20 or 30 more years of trying to cope, in an agonizing and ever-worsening situation, it's small wonder that the only way out may seem to be his or her own death—or that of the patient. And it's also small wonder that it was more than a year before group members could bring themselves to talk of these inevitable feelings about suicide and homicide—feelings that, of course, have nothing to do with intention to act.

Indeed, says Johnson, "One of the greatest fears the caretakers express is that they may die before the patient does. Then who will take care of him?"



Recovery is a team effort for therapists, patient, and family.

If what has been said so far

sounds dismal, the basic tone of the group is far from that. The constant focus is on *coping*—or, as Johnson puts it, on "helping the family control the disability, rather than letting the disability control the family."

For the caretaker, one of the most useful of all coping mechanisms is a brief "escape" from home. Indeed, his or her own health may require it. But finding someone else to take temporary charge of the patient's care isn't easy. And even when suitable arrangements can be made, the caretakers seem to find it almost impossible to leave their patients, even for a few hours. (Said one husband, "I feel as though I'm *abandoning* her.")

Nonetheless, Johnson and Massey continually stress the need for family members to get away from time to time—for part of a day, a weekend, a week, or whatever they can work out. And members of the group who have made their own first "escapes" offer strong encouragement to the others to do likewise.

Humor and fantasy are also important mechanisms in coping, as a recent group session illustrated.

One woman reported that a travel brochure she had recently run across had prompted a week of happy fantasizing. In her scenario, Dr. Massey called her husband back into the hospital for study, just long enough so that she could go on a long-dreamed-of vacation.

To general laughter, another member suggested that the fantasy would have been perfect had she also dreamed up a doctor's order not to visit her husband during his hospital stay—thus averting any possible feelings of guilt.

While the members of the group support each other by sharing problems and working together to find ways to solve them, they also draw strength from broader community aims.

Having themselves found the support of the group invaluable, they hope their experience will spark other efforts to help families in similar plights. To this end, they have generously invited visitors from various "helping" agencies to sit in on sessions, ask questions, and learn firsthand something of the problems families with disabled members face.

Both Johnson and Massey are especially interested in seeing the group idea take root at other facilities besides NNMC. Social workers in the Navy are scarce indeed, Johnson acknowledges. However, she points out, professionals in other disciplines with experience in group dynamics—psychiatrists and chaplains, for example—could lead this type of group just as well.

"You need the skills in group techniques," she says, "but more important than anything else is the *interest!*"

One great problem for doctors in dealing with the disabled, says Massey, is that "they are operating in a vacuum—they don't see the patient in the family context." Yet, he points out, stroke patients at NNMC, for example, stay in the hospital for six weeks at most, and usually go home after two or three.

On NNMC's Neurology Service, the social worker is involved with the family from the beginning of a new patient's hospital stay. (Ideally, the first contact with referred families is made within 24 hours after the patient's admission.) Ms. Johnson's hope is to bring family members into the group right away, so they'll be better prepared for what they'll have to face when the patient goes home.

One area frequently overlooked by the doctor dealing with disabled patients, says Massey, is sex. He himself used to be guilty of this, he says, and he attributes his new sensitivity on the subject to what he has learned in the group: "Two years ago, when patients came back to the clinic, I didn't ask questions about sexual function. Now I try to ask everyone, and patients will say with relief, 'Well, now that you ask . . .'"

In some cases, problems with impotence can be relieved—for example, one patient is now happily functioning after implant of a penile prosthesis. Couples who have difficulty in achieving intercourse because of the partial paralysis of one partner may be helped by counseling on new positions.

But whether or not a sexual problem is susceptible to solution, spouses in such situations need sympathetic understanding in what can be agonizing personal dilemmas.

The problems this article has discussed by no means exhaust the catalog of difficulties that beset families of the disabled. Financial worries, for example, about patients who will sooner or later require nursing-home care have not even been touched on.

Recently, a member of the group expressed his anger toward a physician who had examined his wife and seemed indifferent to signs of regression she was exhibiting. "Well, this is the kind of thing you've got to expect," the doctor told him. "She's not going to get any better; she's going to get worse."

"I didn't *need* anyone to tell me she's not going to get better—I *knew* that," the husband commented indignantly.

Dr. Massey pointed out that the physician's disappointing response could well have resulted from a feeling of helplessness because there was nothing he could do.

"I can have sympathy for that," said Massey. "It's been two years since I came into the group, and my reaction to this type of situation has altered.

"The group has been teaching me, and I'm still learning."

Notes & Announcements

Dental continuing education courses . . . The following dental continuing education courses will be offered in December 1978:

National Naval Dental Center, Bethesda, Md.

Endodontics	4-6 Dec 1978
Comprehensive Dentistry	11-14 Dec 1978

Eleventh Naval District, San Diego, Calif.

Fixed Partial Dentures	4-6 Dec 1978

U.S. Army Institute of Dental Research, Walter Reed Army Medical Center, Washington, D.C.

Preventive Dentistry	4-7 Dec 1978

Letterman Army Medical Center, San Francisco, Calif.

Restorative Dentistry	4-7 Dec 1978

Requests for courses administered by the Commandant, Eleventh Naval District, should be submitted to: Commandant, Eleventh Naval District (Code 37), San Diego, Calif. 92132. Applications for other dental continuing education courses should be submitted to: Commanding Officer, Naval Health Sciences Education and Training Command (Code 5), National Naval Medical Center, Bethesda, Md. 20014. Applications should arrive six weeks before the course begins.

AFIP courses offered . . . The Armed Forces Institute of Pathology will offer the following courses:

Seminars in Diagnostic Radiology 13-17 Nov 1978

These seminars are designed to offer radiology practitioners a summary of the most important morphological principles that underlie the evaluation of roentgenologic signs. Materials have been carefully chosen to achieve maximum radiologic-pathologic correlation in the elucidation of disturbed morphology as seen on roentgenograms.

Applicants should be members of the Medical Corps of the Armed Forces or federal services, or civilians with specialty training in radiology.

Legal Medicine Symposium 14-16 Nov 1978

This course is designed to consider the legal problems developing in the practice of medicine. Risk management and liability control will be emphasized. Systems, organizational structures and accountabilities will also be considered. Programs of prevention, aimed at reducing frequency and severity of hospital and medically related injuries, will be demonstrated by case illustrations. The various presentations are primarily intended to orient hospital administrative, medical, legal, and health insurance personnel to the need for more intensive procedures and controls to eliminate injuries and incidents.

Applicants should be assigned to a medical or legal facility or organization within the federal services. Federal hospital senior medical personnel or claims investigators are especially invited. Applications from other qualified personnel will be considered on a space-available basis.

Basic Forensic Pathology 27 Nov-1 Dec 1978

This course is designed to provide basic training in the special field of forensic pathology, as a supplement to military and civilian residency training programs in pathology. Emphasis is placed on the application of scientific methods to untoward effects of the interaction of man and his environment. The material for this course is presented by specialists in the fields of forensic sciences, law, and investigation through illustrated slide lectures and demonstrations.

Applicants should be resident pathologists, or pathologists in the Medical Corps of the Armed Forces or the federal services. Civilian pathologists, including residents, may apply and be considered on a space-available basis.

Further information may be obtained by writing to the Director, Armed Forces Institute of Pathology, ATTN: AFIP-EDZ, Washington, D.C. 20306.

Patient services training course . . . As a result of increasing needs and demands of the Medical Department patient services community, a new course of instruction has been established by BUMED to train qualified officers for entry-level positions in Patient Services Administration. The curriculum for this program covers medical-records administration, alternative health benefits programs and beneficiaries, quantitative analysis in the health field, auditing and quality assurance, patient disposition, decedent affairs, and organizational behavior.

The five-week program will be conducted at the Naval School of Health Sciences, Bethesda, Md., with the first class of 15 Medical Service Corps officers scheduled to convene on 10 Oct 1978.

Navy cocktail party at ACS meeting . . . In conjunction with the American College of Surgeons meeting in San Francisco, Calif., there will be a Navy cocktail party held on Wednesday evening, 18 Oct 1978, from 6:30 to 9:30, at the Marines' Memorial Club, 609 Sutter Street, San Francisco. For more information contact: CAPT R.M. Deaner, MC, USN, Chairman, Department of Surgery, Naval Regional Medical Center, Oakland, Calif. 94627.

American board certifications . . . (Subspecialties are indicated in parentheses):

American Board of Anesthesiology
LCDR Robert E. Woodruff, MC, USNR
LT Richard H. Balzer, MC, USNR

American Board of Dermatology
CDR Kenneth G. Gross, MC, USNR
LCDR Lauren A. Daman, MC, USNR
LCDR Stephen W. Shewmake, MC, USN

American Board of Endodontics
CAPT Arthur E. Krzeminski, DC, USN
CDR George S. Foster, DC, USN

American Board of Family Practice
CDR William D. Craver, MC, USN
LCDR Thomas W. Coale, MC, USNR
LCDR Rafael K. Deramos, MC, USNR
LCDR Richard L. Harman, MC, USN
LCDR Robert W. Harrison, Jr., MC, USN
LCDR Mark Jacobs, MC, USN
LCDR Oliver K. Williams III, MC, USNR
LCDR George R. Wilson III, MC, USNR
LCDR James W. Wilson, MC, USNR
LT Warren T. Wilson, MC, USNR

American Board of Internal Medicine
CDR Richard G. Daly, MC, USN (Endocrinology and Metabolism)
CDR George A. Luiken, MC, USNR (Medical Oncology)
CDR Stanley I. Thompson, MC, USNR (Cardiovascular Disease)
LCDR Theodore W. Burns, MC, USNR (Gastroenterology)
LCDR George R. Freeland, MC, USN (Gastroenterology)

American Board of Ophthalmology
LCDR Warren L. Broughton, MC, USNR
LCDR Gregory W. Cobb, MC, USNR
LCDR Thomas O. Morris, MC, USNR
LT Fredric D. Young, MC, USNR

American Board of Oral and Maxillofacial Surgery
CDR Roger E. Alexander, DC, USN
LCDR Kenneth J. Davis, DC, USN
LCDR Harvard J. Van Belois, Jr., DC, USN
LCDR Robert J. Vosskuhler, DC, USN

American Board of Pediatrics
LCDR Charles B. Brett, MC, USN
LCDR Johnny H. Dalton, MC, USN
LCDR Stephen M. Golden, MC, USNR (Neonatal-Perinatal Medicine)
LCDR Ulf R. Hierlwimmer, MC, USNR
LCDR John E. Wimmer, Jr., MC, USNR (Neonatal-Perinatal Medicine)

American Board of Periodontology
CDR Dennis R. Ahl, DC, USN
CDR Charles H. Julienne, DC, USN
LCDR Richard R. Gartner, Jr., DC, USN
LCDR James T. Mellonig, DC, USN

American Board of Prosthodontics
CAPT Charles M. Johnson, DC, USN
CDR Edward J. Billy, DC, USN
CDR Mark E. Heilman, DC, USN
CDR Robert W. Hinman, DC, USN
LCDR Thomas A. Lynde, DC, USN

American Board of Surgery
CDR Edsel J. Aucoin, MC, USN
LCDR Martin S. Barber, MC, USN
LCDR Mitchell H. Goldman, MC, USNR
LCDR William R. Rowley, MC, USNR
LCDR John J. Stoltenberg, MC, USNR
LCDR Michael A. Watts, MC, USN

American Board of Urology
CDR George J. Gavrell, MC, USN
CDR Raza M. Khan, MC, USN
CDR Gordon R. MacDonald, Jr., MC, USNR
LCDR Jeffrey H. Kossow, MC, USNR
LCDR Donald E. Sawyer, MC, USNR

American Academy of Microbiology
CAPT Sam W. Joseph, MSC, USN

*Army Board of General Dentistry**
CAPT James V. Gourley, DC, USN
CAPT Ronald K. Harris, DC, USN
CAPT John T. Stevens, DC, USN
CDR Richard B. Finger, Jr., DC, USN
CDR Glenn E. Gordon, DC, USN
CDR Dean D. Schloyer, DC, USN
CDR Gary W. Troutman, DC, USN

*Recognition applicable to military services only

The Medical School Liaison Officer

The complex nature of the Armed Forces Health Professions Scholarship Program places a high premium on the development of effective communication links with students in the field. While the overall responsibility for this task rests with the Surgeon General of the Navy, he is ably assisted by a cadre of inactive Reserve officers who serve as Medical School Liaison Officers at medical and osteopathic schools throughout the United States.

Officers assigned to duty as Medical School Liaison Officers are recruited from among inactive Reserve officers of the Navy Medical Department who hold faculty or administrative appointments at their respective schools. Officers assigned to MSLO duties serve in addition to their primary assignments with Naval Reserve Units. While so assigned, Medical School Liaison Officers perform the following duties:

- Act as the designated representative of the Surgeon General of the Navy at the medical school for all matters pertaining to the Armed Forces Health Professions Scholarship Program.
- Maintain liaison with the Commanding Officer, Naval Health Sciences Education and Training Command, on routine matters pertaining to administration of the Armed Forces Health Professions Scholarship Program.
- Disseminate to Navy scholarship students, on a regular basis, all pertinent information, directives, and other guidance from higher authority.
- Remain responsive to the military needs of scholarship students and assist, where required, in all communications between students and higher authority via the chain of command.
- Provide a point of contact for representatives of the Commander, Naval Recruiting Command, in all matters relating to the recruiting of prospective applicants for the Armed Forces Health Professions Scholarship Program. Assist, when requested, in promoting physician direct appointment recruiting.

At press time, the following officers of the Navy Medical Department were serving as Medical School Liaison Officers for their respective schools:

REGION ONE

DARTMOUTH
CAPT Walter C. Griggs, MC, USNR-R

HARVARD
CDR George Gifford, MC, USNR-R

U. OF MASSACHUSETTS
CAPT Charles I. Brink II, MC, USNR-R

TUFTS
CDR Bradley E. Brownlow, MC, USNR-R

U. OF CONNECTICUT
CDR John Haney, MC, USNR-R

BROWN
LCDR James P. Crowley, MC, USNR-R

YALE
LT Joel Labow, MC, USNR-R

REGION TWO

U. OF VERMONT
CAPT Thomas R. Kleh, MC, USNR-R

ALBANY MEDICAL
LCDR W.J. Paladine, MC, USNR-R

CORNELL
LCDR Carl Bersten, MC, USNR (Ret.)

NEW YORK MEDICAL
CAPT Kirk K. Kazarian, MC, USNR-R

SUNY AT BROOKLYN
CDR Sheldon Bleicher, MC, USNR-R

REGION FOUR

JEFFERSON MEDICAL
CDR Joseph W. Sokolowski, Jr., MC, USNR-R

MEDICAL OF PENNSYLVANIA
CDR Frank I. Marlowe, MC, USNR-R

PENNSYLVANIA STATE
CDR Robert C. Knowles, MC, USNR-R

U. OF PENNSYLVANIA
RADM-Selectee John R. Senior, MC, USNR-R

TEMPLE
CDR George E. Ehrlich, MC, USNR-R

RUTGERS
CAPT Frederic F. Primich, MC, USNR-R

NEW JERSEY COLLEGE OF MEDICINE & DENTISTRY
CDR Norman Ende, MC, USNR-R

REGION FIVE

CASE WESTERN RESERVE
CAPT Alfred D. Heggie, MC, USNR-R

U. OF CINCINNATI
CAPT Thomas H. Joyce, MC, USNR-R

REGION SIX

GEORGETOWN U.
CAPT Herbert G. Hopwood, Jr., MC, USNR-R

HOWARD U.
CAPT Sherman Ross, MSC, USNR-R

JOHNS HOPKINS U.
CAPT Gardner W. Smith, MC, USNR-R

MARSHALL U.
CAPT George J. Hill, MC, USNR-R

EASTERN VIRGINIA MEDICAL SCHOOL
HMCS E.J. Morrison (Ph.D), USNR-R

U. OF VIRGINIA
CAPT Lockhart B. McGuire, MC, USNR-R

REGION SEVEN

BOWMAN GRAY
CAPT John D. Tolmie, MC, USNR-R

U. OF NORTH CAROLINA
CDR D.E. Widmann, MC, USNR-R

U. OF SOUTH CAROLINA
CDR Frank N. Boensch, MC, USNR-R
CDR Wilson B. Rumble, MC, USNR-R

REGION EIGHT

MEDICAL OF GEORGIA
CAPT H. Turner Edmondson, MC, USNR-R

U. OF FLORIDA
CDR James J. Cerda, MC, USNR-R

U. OF MIAMI
CDR Ronald J. Hagan, MC, USNR-R

U. OF SOUTH FLORIDA
CDR James N. Endicott, MC, USNR-R

U. OF KENTUCKY
CDR Jesse Harris, MC, USNR-R

U. OF LOUISVILLE
CAPT Richard F. Greathouse, MC, USNR-R

MEHARRY COLLEGE
CAPT Emerson Emory, MC, USNR-R

U. OF TENNESSEE
CAPT Joseph H. Miller, MC, USNR-R

VANDERBILT
CAPT Raphael F. Smith, MC, USNR-R

U. OF ALABAMA
CAPT Charles E. Herlihy, MC, USNR-R

U. OF SO. ALABAMA
CAPT Leland Edmonds II, MC, USNR-R

U. OF MISSISSIPPI
CAPT Frank J. Morgan, MC, USNR-R

REGION TEN

LOUISIANA STATE U. AT NEW ORLEANS
CAPT Roy H. Barnes, MC, USNR-R

LOUISIANA STATE U. AT SHREVEPORT
CAPT Norman L. Mauroner, MC, USNR-R

TULANE
CDR William A. Martin, MC, USNR-R

U. OF ARKANSAS
CDR Jerry L. Thomas, MC, USNR-R

BAYLOR
CAPT Paul B. Radelat, MC, USNR-R

U. OF TEXAS AT GALVESTON
CDR Daniel L. Creson, MC, USNR-R

REGION ELEVEN

TEXAS TECH
CAPT Joseph R. Sasano, Jr., MC, USNR-R

U. OF OKLAHOMA
CDR Lawrence D. Amick, MC, USNR-R

MICHIGAN STATE
CDR James Jackson, MC, USNR-R

U. OF MICHIGAN
RADM Park W. Willis, MC, USNR-R

INDIANA U.
LCDR John M. Doty, MSC, USNR-R

U. OF CHICAGO
CDR Stanton Polin, MC, USNR-R

LOYOLA
CAPT William Ertl, MC, USNR-R
CDR Mario D. Oriatti, MC, USNR-R

NORTHWESTERN
LCDR John K. Hurley, MC, USNR-R

U. OF WISCONSIN
CDR Thomas D. France, MC, USNR-R

REGION SIXTEEN

U. OF IOWA
CAPT Peter R. Jochimsen, MC, USNR-R

MAYO MEDICAL
CAPT Harry Bisel, MC, USNR-R

U. OF MINNESOTA AT MINNEAPOLIS
CAPT Richard Woellner, MC, USNR-R

U. OF SOUTH DAKOTA
CDR James K. Jackson, MC, USNR-R

REGION EIGHTEEN

U. OF MISSOURI AT COLUMBIA
CDR William C. Allen, MC, USNR-R

SAINT LOUIS U.
RADM Matthias Backer, Jr., MC, USNR-R

U. OF KANSAS CITY
CDR James H. Chapman, MC, USNR-R

U. OF NEBRASKA
CDR Wm M. Berton, MC, USNR-R

U. OF COLORADO
RADM Ben Eiseman, MC, USNR-R

REGION NINETEEN

U. OF ARIZONA
CAPT James A. Austin, MC, USNR-R
CAPT George H. Mertz, MC, USNR-R

U. OF CALIFORNIA AT IRVINE
CDR Glenn W. Fowler, MC, USNR-R

U. OF CALIFORNIA AT LOS ANGELES
CAPT Harry T. Wright, Jr., MC, USNR-R

U. OF CALIFORNIA AT SAN DIEGO
CDR Kenneth M. Moser, MC, USNR-R

U. OF SO. CALIFORNIA
CAPT James T. Helsper, MC, USNR-R
CAPT Harry T. Wright, Jr., MC, USNR-R

REGION TWENTY

U. OF UTAH
LCDR William C. Vincent, MC, USNR-R

U. OF CALIFORNIA AT DAVIS
CAPT Walter A. Tatge, MC, USNR-R

U. OF CALIFORNIA AT SAN FRANCISCO
CAPT Richard J. Bartlett, MC, USNR-R

STANFORD
CAPT Franklin G. Ebaugh, MC, USNR-R

REGION TWENTY-TWO

U. OF OREGON
CAPT Richard M. Bernard, MC, USNR-R

U. OF WASHINGTON
CDR James R. Hooley, DC, USNR-R

SCHOOLS OF OSTEOPATHIC MEDICINE

KANSAS CITY COLLEGE
LCDR James H. Chapman, MC, USNR-R

MICHIGAN STATE
LCDR John R. Downs, MC, USNR-R

KIRKSVILLE COLLEGE
CAPT James J. Woodruff, MC, USNR-R

Instructions & Directives

New Hospital Corpsman specialty established

In May 1974, BUMED approved the formal training of Ocular Technicians, and BUPERS approved the assignment of the NEC HM-8444 for this training. It was planned at that time that the training of Advanced Ocular Technicians would be approved at such time as the manning in NEC HM-8444 permitted. This manning has been attained, and BUMED has approved the training of Advanced Ocular Technicians through on-the-job training (OJT). BUPERS has approved assignment of the NEC HM-8445.

The following activities have been approved for establishment of an OJT Program for Advanced Ocular Technician, HM-8445:

- CO, NATNAVMEDCEN, Bethesda, Md.
- CO, NAVREGMEDCEN, San Diego, Calif.
- CO, NAVREGMEDCEN, Portsmouth, Va.
- CO, NAVREGMEDCEN, Oakland, Calif.

Designation of billets and realignment have been accomplished at headquarters level, effective April 1978.

Commanding officers should provide widest possible dissemination of the information and changes included herein.

A number of NEC change recommendations have been received by BUMED, certifying completion of OJT in advanced ocular technique. Each request will be evaluated to ensure that the training received is officially recognized.

Commands that have HM-8445 requirements but are not authorized to conduct OJT will have their requirements met by normal sea/shore rotation as qualified personnel become available.

All OJT in NEC HM-8445 initiated after 1 July 1978 must be in compliance with BUMEDINST 1510.10D.—BUMED Notice 1510 of 27 June 1978.

Mercury vapor hazard

The purpose of this notice is to provide a method for eliminating the mercury vapor hazard in dental operating rooms that utilize the Denta-Vac air-operated vacuum system manufactured by A-dec, Inc., 2601 Crestview Drive, Newberg, Ore. This device is used to remove debris, saliva, amalgam scraps, etc., from the patient's mouth while dental procedures are being performed.

Enclosure (1) of this notice provides detailed instructions for modifying the Denta-Vac to prevent mercury vapor from being exhausted to the environment.

All Denta-Vacs presently installed in dental operating rooms aboard ships and at dental clinics ashore should be modified. Without this modification, the Denta-Vac will exhaust mercury vapors into the dental operatory.—BUMED Notice 6260 of 9 May 1978.

Transfer of health records to NPRC, St. Louis

Because of numerous reports of discrepancies in record-transfer procedures received by the National Archives and Records Service, GSA, OPNAV has requested BUMED to direct corrective action.

In terms of the number of reports received, *the Medical Department is one of the largest offenders,* compared with other Navy activities, in not following correct procedures for transferring health care treatment records to the National Personnel Records Center (NPRC) at St. Louis, Mo. The following discrepancies are most frequently cited:

- **Records intermix.** Inpatient, outpatient, and emergency room treatment records of military personnel and dependents have not been separated and are being shipped intermixed, requiring the records of dependents and other supernumerary patients to be retained at NPRC unnecessarily for 25 years beyond the normal disposal date.
- **SF 135, Records Transmittal and Receipt.** Advance notice copy not sent to NPRC at least 2 weeks prior to shipping data; obsolete SF 135 used; form not signed; required number of copies not sent; description of records and years covered not entered on form; disposal authority cited incorrectly or not cited; etc.
- **Other.** Standard shipping cartons not used; nominal (name) index to records not included in shipment; records shipped to wrong address.

A properly conducted records disposition program is an essential function in the administration and cost-effective management of naval health care facilities. Local programs interface with and directly affect the NPRC in maintaining an automated inventory system, storing records, and providing prompt retrieval service. Medical Department records have a long-term value to patients and are vital to protecting the interest of the Government.

Each discrepancy in the transfer of health care treatment records to NPRC results in delay and a *preventable* loss of resources by the Medical Department. The National Archives and Records Service, GSA, has advised that unless the deficiencies in records shipments received from naval activities are corrected, NPRC will be directed to refuse acceptance. Records shipped to NPRC with major deficiencies will be returned at Medical Department expense.

Effective immediately, ships and stations having medical personnel shall fully comply with the detailed instructions on record transfer provided as enclosure (1) of this notice.—BUMED Notice 5212 of 29 June 1978.

Yellow fever vaccine

Since 3 Jan 1978, the yellow fever vaccine previously produced and distributed by Merrell-National Laboratories, Inc., has been manufactured by Connaught Laboratories, Inc., Swiftwater, Pa. 18370, and is being distributed by Elkins-Sinn, Inc., 2 Esterbrook Lane, Cherry Hill, N.J. 08002. After 28 Feb 1978, Merrell-National was to cease all distribution; however, because the expiration date of their vaccine is 28 Feb 1979, it may be available for administration through that date.

International certificates of vaccination against yellow fever *before* 28 Feb 1979 may list either Merrell-National or Connaught under the heading "manufacturer," depending upon the brand of vaccine administered. Certificates completed *after* 28 Feb 1979 must list Connaught as manufacturer; otherwise, the certificate is invalid and the traveler may have to be revaccinated before entering those countries that require a valid certificate.—BUMED Notice 6230 of 18 April 1978.

TD2 D. W. English is about to learn what bailout from a high-performance aircraft is like, courtesy of a Navy ejection-seat trainer (San Diego, 1953).

In good times and in lean ones, a 'can do' spirit has been the program's hallmark

Naval Aviation Physiology

LCDR Terrence J. O'Leary, MSC, USN

During World War I—because the primary role of naval aviation was antisubmarine warfare—most Navy flying was done at low speed and low altitude. As a result, there was little or no appreciation of the stresses of high-altitude flight.

By the end of the war, however, aircraft were available that could attain an altitude of 25,000 feet. As higher flights became more routine, the need for a supplemental oxygen supply for pilots became apparent.

In 1927, a letter from the Chief of the Bureau of Aeronautics indicated that 2,000 oxygen tanks that had been purchased by the Navy in 1922 (probably for welding purposes) could be used for aviation. (At that time, oxygen was supplied to the aviator through a pipestem hooked over his lip.)

In 1929, a memorandum endorsement from the Director of Fleet Training to the Chief of Naval Operations emphasized the importance of supplemental oxygen for high-flying pilots (*1*):

> It is apparent that the use of oxygen at altitudes of 15,000 to 16,000 feet is not necessary for safety but is extremely desirable in that the physical and mental capability of the pilot is increased. Above these altitudes, the necessity for oxygen increases and the factor of safety to personnel enters.

In February 1940—with prewar naval activities on the increase—the Medical Research Section of the Bureau of Aeronautics recommended that facilities be procured to provide oxygen indoctrination for all flying personnel. Through lectures and training films, instruction was to be given on the effects of "anoxia" (lack of oxygen) at altitude, and on the use of oxygen equipment. Practical demonstrations were to be provided in low pressure chambers, where flight personnel could experience firsthand the consequences of anoxia and the benefits of supplemental oxygen.

In July of the same year, the Bureau of Aeronautics approved installation of low pressure chambers at the basic flight training schools at Pensacola, Corpus Christi, Miami, and Jacksonville.

In May 1941, LT H. J. Rickard, MC, USNR, LT T. D. Boaz, MC, USN, Pharmacist's Mate First Class H. G. Leak, and Water Tender First Class J. Krohn were ordered by the Bureau of Navigation to proceed to the Navy Department in Washington for two weeks' training as members of the Navy's first Altitude Training Unit (*2*).

This group spent the first week with the Experimental Diving Unit at the Washington Navy Yard, where there was a low pressure chamber, used primarily for research and development, and staffed by qualified divers. The group's second week was spent in Boston at the Harvard School of Public Health, which also had a low pressure chamber and was already training two Army flight surgeons in high-altitude problems.

By June the four were in Pensacola, where they gave a two-week course of instruction to prospective training-unit personnel from the other basic flight schools and began the training of cadets.

Of the early altitude instructors, Williams and Barr (*3*) wrote:

> One of the major accomplishments of the . . . program during 1941 and 1942 was to dispel misconceptions concerning the use of oxygen. It was commonly believed that breathing 100 percent oxygen was harmful, that strong men did not need supplemental oxygen until they reached comparatively high altitudes, and that only the

LCDR O'Leary is a naval aviation physiologist assigned to the NNMC Branch Clinic, Washington, D.C., with additional duty to the 1099th Physiological Training Flight, Malcolm Grow USAF Medical Center, Andrews AFB, Md. 20031.

physically weak needed to use oxygen at low altitudes. To many, use of oxygen at low altitudes was an admission of weakness and lack of stamina. These misconceptions were so prevalent and firmly ingrained that altitude training personnel soon found themselves selling the use of oxygen to aviation personnel.

Demonstrations were given in low pressure chambers like the one at Pensacola, described by Boaz (*4*):

> The chamber, which is cylindrical in shape, is 20 feet long, 8 feet in diameter, and is divided into 2 compartments; the larger is 16 feet long, containing 14 seats (7 along each side), and the smaller or lock compartment being merely 4 feet long and containing 2 seats on each side. The 2 compartments may be operated separately when the door between them is secured. This is of importance for individuals who become distressed during a simulated high-altitude run. They may be transferred to the lock compartment and brought quickly to atmospheric pressure while the others remain at the simulated high altitude and complete the "flight."

By late 1941, the four low pressure chambers originally ordered had become so overworked that six more were procured for other air stations. (For oxygen training in fleet units, six mobile chambers were procured in 1943.)

In November 1941, wrote Williams and Barr (*3*):

> . . . plans were developed for a program of pilot declassification based on each aviator's tolerance to anoxia, chilling, and air embolism . . . During 1942 the Altitude Training Unit at Pensacola conducted investigations aimed at the establishment of measures of altitude tolerance. Reactions to hypoxia at altitudes of 18,000 and 18,500 feet were studied . . . Installation of the first refrigerated low pressure chamber was completed at Pensacola in December 1942.

Cadets had to demonstrate a tolerance for temperatures as low as -30°F while at a simulated altitude of 30,000 feet. Those showing lesser tolerances were limited to flying low-altitude aircraft.

A course of instruction in low pressure chamber technology, leading to the designation "low pressure chamber technician," was established in 1941 for hospital corpsmen (pharmacist's mates), and Altitude Training Units began giving the course in 1942. In December 1943, the first classes of WAVE corpsmen began this training, so they could replace male corpsmen needed for fleet assignments.

Pollard (*5*) wrote that there were 10 medical officers trained at Pensacola in 1942 "as instructors to inaugurate low pressure chamber training at their respective duty stations. Also, H-V(S) officers were trained as instructors."

"H-V(S)," for "Hospital Corps-Volunteer (Specialist)," was a designation given to certain officer specialists brought into the Navy in World War II. These

Aviation cadets at work in NAS Pensacola's refrigerated low-pressure chamber, installed in December 1942.

H-V(S) officers were the predecessors of Medical Service Corps aviation physiologists. At the time, however, they were designated "environmental physiologists."

Ensigns Wilson C. Grant, Arthur H. Smith, and Daniel T. Watts formed the first class of physiologists to receive altitude training.

ENS Smith arrived at Pensacola in April 1942, a month early for training, and was temporarily assigned to work with LT Peckham, an aviation psychologist who was developing a night vision training program.

Of his subsequent altitude indoctrination, Smith says, "Nobody talked to us—we just learned by OJT." Not until two or three classes later was a formal curriculum established.

In December of that year, Smith was transferred to MCAS Cherry Point, N.C., to establish an Altitude Training Unit there. Subsequently he was assigned to NAS Jacksonville, then to MCAS Santa Barbara, where he served as the night vision training officer until February 1946.

For Grant there are some vivid memories of Pensacola in 1942.

One is of the visit of First Lady Eleanor Roosevelt, who arrived during an inspection tour to learn where women might fit into the Navy training program. While at Pensacola she went through a low pressure

chamber flight on which ENS Grant was an observer. The original intention was to take Mrs. Roosevelt on a "flight" to only a few thousand feet; however, despite lengthy explanations of potential discomforts, she insisted on sharing the experience of the student pilots.

Another memory is an unhappy one, for Grant was a witness to the plane crash in which CDR Eric Liljencrantz—the Navy's first flight surgeon to die in an aircraft accident—was killed. Grant had been flying in the same aircraft on the flight just before the fatal accident.

After leaving Pensacola in December 1942, ENS Grant served in the Altitude Training Unit at NAS Norfolk for three or four months before becoming a line officer. Eventually, he switched to PT boats, arriving in the Philippines just as the war ended.

The third classmate, ENS Watts, had joined the Navy as a line officer, in his rush to enter the war effort. After three months' active duty at Key West, he became an H-V(S) officer and was ordered to Pensacola in May 1942 for altitude training.

After a subsequent tour at NAS Alameda, he served from early 1944 until 1947 at the Naval Air Experimental Station, Philadelphia, carrying out some of the early human-factors research leading to development of the first Navy ejection seat. Two special visitors to the station during that time were Charles Lindbergh and James Doolittle, whom Watts laconically describes as "characters—especially Doolittle."

Early in 1943, NAS Jacksonville's Altitude Training Unit established a course of instruction leading to the designation "oxygen officer." A few of the students were physiologists, but most were pilots who had been disqualified from flying, cadets who had not completed flight training, and others.

Since at the time there was no such thing as a test stand to check oxygen equipment, these people were tasked with checking each pilot's equipment prior to flight— and occasionally at altitude in an aircraft. They were often assigned to an Altitude Training Unit; however, they spent most of their time with the squadrons.

Later, air-sea rescue and survival training was added to the "oxygen officer" course, and the designation for graduates was changed to "aviation equipment and survival officer." A school similar to Jacksonville's was established at Pensacola in 1944, and by the end of 1945 the two schools had trained more than 400 officers (*3*).

By 1943, rapid expansion of the aviation training and pilot declassification program had begun making it difficult for Altitude Training Units to comply with the numerous directives they were receiving. Shortages of trained medical personnel were occurring. Moreover, ground- and flight-training syllabuses for cadets were too crowded to allow enough time for the oxygen indoctrination courses and altitude classifications requested by the Bureau of Aeronautics. In short, the program was becoming a major administrative problem.

In April 1943, the Bureau of Aeronautics asked BUMED to assume responsibility for the program, and within a few months altitude training had become the program's primary mission (*3*).

Describing developments during this period, Pollard (*5*) wrote:

> The Bureau of Medicine and Surgery established a Low Pressure Chamber and Oxygen Section under its Division of Aviation Medicine in June 1943 and subsequently administered the development of training techniques, the conduct of high altitude training for the training commands and the fleet, and provided trained instructors and supervisory personnel. The conduct of the training at the local level was placed under the direct supervision of the local senior medical officer. Assistance was obtained from locally assigned junior flight surgeons.

It should be noted that early in the program not all Altitude Training Units had physiologists assigned. In those that did, a flight surgeon was still directly in charge, and the physiologist served as his assistant.

With the war at an end, the training of corpsmen as low pressure chamber technicians was discontinued in late 1945.

Summer 1946 saw a massive exodus of personnel and, wrote Pollard (*5*), "aviation physiology training collapsed due to the release of trained instructors from active duty."

But progress in the science of aeronautics—and the advent of more sophisticated aircraft—assured that the setback would be only temporary.

By this time the Navy was developing ejection seats for its high-performance aircraft, and on 30 Oct 1946 former ENS Daniel T. Watts—by then a lieutenant commander—was witness to the first live Navy ejection from an airborne platform.

The aircraft was a JD-1, and the volunteer was LTJG A. J. Furtek, who had been a qualified parachutist as an enlisted man and had later become a naval aviator.

The ejection process was supposed to work like this: After ejection had been initiated, a static line, attached to the aircraft, was to open the main parachute, which was attached to the ejection seat. When descent of the seat had been slowed down, the occupant was to disconnect himself, fall away from the seat, and open his personal parachute.

After five perfect dummy trials, it was decided to try a live firing. With the aircraft at about 10,000 feet, flying at about 205 mph, Furtek began his ejection; however, the main parachute failed to open completely. To observers, Furtek seemed slow in getting out of the seat, but he finally pushed himself out at about 1,500 feet above ground. He fell some 200 feet more before getting his parachute open and landing safely.

Until the establishment of the Allied Science Branch of the Medical Service Corps in 1948, there was no established career pattern in the Navy to attract

At Pensacola, WAVES teach aviation cadets proper use of oxygen equipment (1943).

aviation physiologists," Pollard (*5*) wrote. He noted that although flight surgeons tried to conduct aviation physiology training, there were too few of them to do so adequately. Thus, "the unavailability of instructors was an important factor in the slow revitalization of training."

At the 1948 Naval Air Training Command Conference, according to Pollard, a "general strengthening of the training was recommended, including the addition of regularly scheduled refresher training for fleet pilots." Still, the end of 1950 saw just four aviation physiologists on active duty.

LT Elizabeth Reeves, stationed at North Island, was the only physiologist who had come on board during World War II and had remained on continuous active duty. LTs Glenna Cahill, stationed at Jacksonville, and Mary F. Keener, at Norfolk, had been asked to return to active duty to help revitalize the program. CDR Roland A. Bosee, at El Centro, had been a naval aviator during World War II and had converted to aviation physiology in 1947.

In early 1951, a 10-week course was conducted for the first class of student "applied aviation physiologists" in six years. The five graduates were LTJG Bill Archer, assigned to Philadelphia; LTJG Kenneth Coburn, to Pensacola; LTJG Tom Ferris, to Atlantic City; ENS Harold Bower, to North Island; and ENS Morris Damato, to Corpus Christi.

In March of that same year, BUMED accepted the Navy's first portable ejection seat tower designed exclusively for training purposes. The prototype was installed at NAS North Island for evaluation by the Altitude Training Unit, with LCDR Marvin Courtney (MC), a flight surgeon, as project officer. Shortly thereafter, ejection seat trainers were installed at all training unit locations.

The first female aviation physiologist to enter the program after World War II was ENS Nancy Murtagh, who completed her training in fall 1951 and was assigned to NAS Alameda. She says she initiated the push for hazardous duty incentive pay (HDIP) for officers and enlisted personnel routinely making low pressure flights, having begun her work on the HDIP proposal around 1953.

In June 1954, a bill introduced in the Senate included the statement that "duty as low-pressure chamber inside instructor" entitled individuals assigned by competent authority to HDIP. The resulting Career Incentive Act of 1955 set the monthly HDIP for officers at $110; for enlisted personnel at $55.

In early 1959, the Hospital Corps NEC of 8409 was established for low pressure chamber technicians. These individuals had to be qualified aviation medicine technicians (AVTs) who had received on-the-job training with Altitude Training Units. (Around 1962, a formal low pressure chamber technician course was established for selected volunteers, and in 1963 the designation for these individuals was changed to "aviation physiology technician.")

In 1961 an ADDU billet—Head, Aviation Physiology Branch—was established at BUMED, and CAPT Mary F. Keener was appointed to fill it. (The billet became full-time in 1965 but was lost in 1976 because of personnel cuts following the Vietnam conflict.)

Late in 1962, LCDR Harold Bower presented a proposal to CAPT Clifford Phoebus, Commanding Officer of the Naval Aerospace Medical Institute, Pensacola, concerning the training of naval aviation physiologists. Under the proposal, preflight and flight training would be added to the curriculum—a measure that would lengthen the course from ten weeks to nearly six months. Also, naval aviation physiologists would become designated aircrew members, rating flight pay and the right to wear wings. The purpose of the proposal was to ensure that the training physiologists provided would be oriented, not just to the low pressure chamber, but to the real world of aviation.

In January 1963, LCDR Bower and CAPT Phoebus presented the proposal at BUMED to CAPT Keener; CAPT Merrill H. Goodwin, Assistant Chief for Aviation Medicine; and CAPT Robert S. Herrman, Chief of the Medical Service Corps—all of whom liked the idea.

In December 1965, LT Durward Rhoades, ENS Tom Bird, and ENS Robert L. Smith became the first aviation physiologists to complete the new flight-training syllabus. On 10 Jan 1966, the Secretary of the Navy approved the designation of naval aviation physiologists as aircrew members. And on 12 April 1967, a change in the U.S. Navy Uniform Regulations permitted wearing of wings by designated naval aviation physiologists.

Early in 1970, CDR Paul W. Scrimshaw—who had relieved CAPT Keener at BUMED—called a meeting of some of the senior aviation physiologists to standardize Navy physiology training procedures and syllabuses. The resulting changes went into effect in fall 1970 and included expansion of the night vision lecture to cover various aspects of visual problems, vertigo, and disorientation. Added to the oxygen equipment lecture was a briefing on all pertinent items of aircrew protective and survival equipment.

In January 1975, LCDR David G. Smith (MSC) entered the Aviation Safety Officers School at Monterey, becoming the first of a growing number of naval aviation physiologists in the Aeromedical Safety Operations (AMSO) program. Awareness of the need for more emphasis on the medical aspects of aviation safety—and recognition of the additional services the naval aviation physiologist can provide—has made the physiologist an integral part of the AMSO team.

Recent developments in aviation physiology have included interservice programs with the Air Force.

In 1976, LCDR Terrence J. O'Leary (MSC), HM1 Billy J. Cox, and HM1 Claude Carroll became the first naval aviation physiologist and aviation physiology technicians to work in an Air Force training unit (at Andrews AFB, Md.).

Simultaneously, CAPT John Graham, BSC, USAF, became the first Air Force physiological training officer to work in a Navy training unit (at Barbers Point, Hawaii).

In February 1977, HM2 John Lawlor, HM2 Jeffrey L. Munson, HM2 James Neeley, and HM3 Marlon Evans became the first aviation physiology technicians to be trained by the Air Force (at Brooks AFB, Tex.).

The history of any program is a history of people. The people in this program have always been willing to take on the job at hand—with a can-do spirit and with devotion to the U.S. Navy. Their spirit and enthusiasm have brought growth to this program while—in these times of austerity—others have not fared as well.

References

1. West VR, Every MG, Parker JF Jr (eds): *U.S. Naval Aerospace Physiologist's Manual.* NAVAIR 00-80T-99, 1972, pp 1-21.

2. Rickard HJ: Medicos in the stratosphere. Contact 1:12-17, Aug 1941.

3. Williams NE, Barr NL: *The History of the Medical Department of the United States Navy in World War II.* NAVMED P-5031, 1953, pp 212-218.

4. Boaz TD: Low pressure chamber installed at the Naval Air Station, Pensacola, Florida. US Nav Med Bull 40(2):429-439, 1942.

5. Pollard JP: Some aspects of physiology training in naval aviation. Milit Med 126:133-139, 1961.

Hospital Corps Career Decision:

The Time Is Now!

If you're contemplating leaving the Hospital Corps because you think your advancement opportunities, educational pursuits, or chances for travel and rewarding assignments are stifled, think again.

Advancement. The chances for advancement within the Hospital Corps are increasing. The following breakdown portrays the selection and advancement of hospital corpsmen, E-4 through E-9, during the most recent advancement cycle:

- E-9: 106 board eligible; 44 (41.5%) selected.
- E-8: 651 board eligible; 122 (18.7%) selected.
- E-7: 704 board eligible; 323 (45.9%) selected.
- E-6: 942 test takers; 381 (40.4%) advanced.
- E-5: 2,198 test takers; 683 (31.0%) advanced.
- E-4: 1,688 test takers; 1,688 (100%) advanced.

As can readily be determined, advancement within the Hospital Corps is alive and well.

Education. The Hospital Corps has 31 advanced schools available for qualified men and women. The training for health-care paraprofessionals in today's Hospital Corps is commensurate with—and in many cases better than—civilian training. The list of advanced studies below is indicative of opportunities as they are today and will be tomorrow:

Nuclear Submarine Medicine
Aviation Medicine
Surface Nuclear Medicine
Cardiopulmonary
Aviation Physiology
Clinical Nuclear Medicine
Advanced Hospital Corps
Preventive Medicine
Transplantation
Ocular
Otolaryngology
Radiology
Electroencephalography
Optician
Physical/Occupational Therapy
Medical Photography
Biomedical Equipment, Basic
Biomedical Equipment, X-ray
Biomedical Equipment, Electronics
Pharmacy
Operating Room
Neuropsychiatry
Urology
Special Operations
Medical Deep Sea Diving
Dermatology
Basic Laboratory
Cytology
Histopathology
Advanced Laboratory
Medical Technologist

Many of the above courses of instruction are wide open to qualified candidates. Among these are Nuclear Submarine Medicine; Advanced Hospital Corps; Preventive Medicine; Optician; Biomedical Equipment, X-ray; Biomedical Equipment, Electronics; Pharmacy; and Special Operations.

Corpsmen with certain technical skills are paid extra money upon reenlistment and during their tours of duty. These are generally the operational skills, such as Nuclear Submarine Medicine, Special Operations, and Medical Deep Sea Diving.

Several Hospital Corps schools are affiliated with, and accredited by, civilian colleges and universities, and students receive college credit upon completion of the course.

Billets. Navy Hospital Corps billets are available in every state in the Union and at many overseas locations. Depending on skills possessed, pay grade, performance, etc., hospital corpsmen can look forward to rewarding tours of duty. A recent survey revealed that approximately 75% of all assignments were made based on the duty preferences of the individual.

The Guard II program, soon to be replaced by Guard III, allows qualified hospital corpsmen literally to select their next duty station as a reenlistment incentive. This program rewards good performance and definitely allows the corpsman to detail himself.

If you take into account:

- the opportunity for advancement,
- the opportunity to acquire a technical skill within the health-care field,
- the opportunity to pursue your education,
- the opportunity to select your next assignment,
- the opportunity to increase monetary rewards,
- the opportunity to be a part of the best health-care system in the Armed Forces, and
- the opportunity to perform a service to your shipmates—

The time to decide on a career in the Hospital Corps is now!

—HMCM Marty Luchter, USN, Senior HM Detailer, BUPERS

CUT ALONG THIS LINE

NOTES

FOLD

ROSTER–1 AUGUST 1978

Following is a list of staff medical and dental officers of major fleets and forces; district medical and dental officers; commanding officers; executive officers; directors of administrative services; directors of clinical services; chief nurses of Medical Department activities; division surgeons and dental officers of Marine divisions, Marine aircraft wings, and Marine brigades.

CINCPACFLT/CINCPAC (ADDU)	RADM D.E. BROWN, JR., MC, USN (ADDU)
CINCPACFLT	CAPT N.D. WILKIE, DC, USN (ADDU)
CINCPACFLT	AO CAPT J. WOLF, MSC, USN
CINCLANT/CINCLANTFLT/SACLANT (COMTRALANT)	RADM E.P. RUCCI, MC, USN
CINCLANT/CINCLANTFLT/CINCWESTLANT	RADM J.B. HOLMES, DC, USN
CINCLANTFLT	AO CDR W. BRANSCUM, MSC, USN
SACLANT	AO CDR W.I. CASLER, MSC, USN
CINCUSNAVEUR	CAPT H.E. SHUTE, MC, USN (ADDU) CAPT R.S. NOLF, DC, USN (ADDU)
COMNAVFOR JAPAN	CAPT B.L. JOHNSON, MC, USN (ADDU) CAPT E.T. WITTE, DC, USN (ADDU)
COMNAVLOGISTICS	RADM D.E. BROWN, JR., MC, USN AO CDR C.A. ROPER, MSC, USN
COMNAVAIRLANT	CAPT R.P. CAUDILL, MC, USN CAPT S.W. PERAND, DC, USN (ADDU)
COMNAVAIRPAC	CAPT F.E. DULLY, MC, USN CAPT A.L. DAVY, DC, USN (ADDU) AO LCDR C. SCHMUTZ, MSC, USN
COMSUBLANT	CAPT B.J. BLANKENSHIP, MC, USN
COMSUBPAC	CAPT R.T. LARSEN, MC, USN CAPT N.D. WILKIE, DC, USN (ADDU)
CNET (NAS PNCLA)	RADM R.L. BAKER, MC, USN (ADDU) CAPT T.W. MC KEAN, DC, USN (ADDU) AO CAPT S.D. BARKER, MSC, USN (ADDU)
CNATECHTRA (NAS MEMPHIS, TN)	CAPT C.W. BRAMLETT, MC, USN (ADDU) CAPT D.G. GARUER, DC, USN (ADDU) AO LCDR W.F. BENEDICT, MSC, USN
CNAT (NAS CORPUS CHRISTI, TX)	CAPT T.J. TRUMBLE, MC, USN (ADDU)
COMNAVSURFLANT	CAPT W.M. PHILLIPS, MC, USN CAPT C.E. BRANYAN, DC, USN (ADDU)
COMNAVSURFPAC	CAPT J.W. JOHNSON, MC, USN CAPT R.E. THOMAS, DC, USN (ADDU) AO LCDR R.W. BARNHILL, MSC, USN
COMNAVFORCARIB/COM ANTILLES DEF COMD	CAPT P.C. GREGG, MC, USN (ADDU) CAPT D.E. BARLOW, DC, USN (ADDU)
COMFAIRMED	CAPT J.A. MC KINNON, DC, USN (ADDU)
COMICEDEFOR	CAPT M.C. CLEGG, DC, USN (ADDU)
COMTRAWING 4	CAPT A.D. SORENSON, DC, USN (ADDU)
OPNAV	CAPT C.A. BROWN, DC, USN (ADDU)
OFFNAVRESCH, WASHINGTON, DC	CAPT J.F. KELLY, DC, USN (ADDU)

FIRST NAVAL DISTRICT	DMO CAPT V.L. STOTKA, MC, USN (ADDU) DDO CAPT W.A. PETERSON, DC, USN
NAVREGMEDCLINIC, PORTSMOUTH, NH	CO CDR D.W. REEVES, MSC, USN XO LCDR D. MC DERMOTT, MSC, USN SR NURSE CDR M. BRAXMAN, NC, USN
NAVREGMEDCEN, NEWPORT, RI	CO CAPT V.L. STOTKA, MC, USN DCS CAPT C.M. VOYLES, MC, USN DAS CDR N.K. OWENS, MSC, USN CH NURSE CAPT L. ROBINSON, NC, USN
NAVREGDENCEN, NEWPORT, RI	CO CAPT W.A. PETERSON, DC, USN DCS CAPT C.J. SCHULTZ, DC, USN DAS LT J.C. WANAMAKER, MSC, USN
THIRD NAVAL DISTRICT	DMO CAPT L.H. SEATON, MC, USN (ADDU) AO LT D. SUTTLE, MSC, USN (ADDU)
SUB MEDICAL CENTER, NEW LONDON, CT	CO CAPT L.H. SEATON, MC, USN DCS CAPT R.B. JOHNSON, MC, USN DAS CAPT F.G. ANDERSON, JR., MSC, USN CH NURSE CAPT A. BARKER, NC, USN
SUBMEDRSCHLAB, GROTON, CT	CDR R.A. MARGULIES, MC, USN
FOURTH NAVAL DISTRICT	DMO CAPT R.A. BAKER, MC, USN (ADDU) DDO CAPT A.F. REID, DC, USN (ADDU) AO LT J.N. GALLIS, MSC, USN (ADDU)
NAVREGMEDCEN, PHILADELPHIA, PA	CO CAPT R.A. BAKER, MC, USN DCS CDR C.T. CLOUTIER, MC, USN DAS CAPT H.S. RUDOLPH, MSC, USN CH NURSE CAPT A. FOLEY, NC, USN
NAVREGDENCEN, PHILADELPHIA, PA	CO CAPT A.F. REID, DC, USN DCS CAPT H.E. FREEBURN, JR., DC, USN DAS LT O.J. SANTORE, JR., MSC, USN
NAVAL MEDICAL MATERIAL SUPPORT COMMAND, PHILADELPHIA, PA	CO CAPT O. STALLINGS, MSC, USN XO LCDR R.P. LEGG, MSC, USN
FIFTH NAVAL DISTRICT	DMO RADM G.E. GORSUCH, MC, USN (ADDU) DIR DENACTYS RADM J.B. HOLMES, DC, USN (ADDU) AO LCDR R.M. CURRAN, MSC, USN (ADDU)
NAVREGMEDCEN, PORTSMOUTH, VA	CO RADM G.E. GORSUCH, MC, USN DCS CAPT J.W. HAYES, MC, USN DAS CAPT D.E. SHULER, MSC, USN CH NURSE CAPT M.P. BRENNAN, NC, USN
NAVAL SCHOOL OF HEALTH SCIENCES, PORTSMOUTH, VA	OIC CAPT B.A. MC KAY, NC, USN AO LT G. MURPHREE, MSC, USN
NAVREGDENCEN, NORFOLK, VA	CO RADM J.B. HOLMES, DC, USN DCS CAPT W.E. QUILTER, JR., DC, USN DAS CDR C.A. WESOLOWSKI, MSC, USN
NAVAL BASE, NORFOLK, VA	RADM J.B. HOLMES, DC, USN (ADDU)
NAVAL OPHTHALMIC SUPPORT & TRAINING ACT, WILLIAMSBURG, VA	CO CAPT J.G. WILCOX, MSC, USN XO CDR R.L. GOOCH, MSC, USN
NAVHOSP, CHERRY POINT, NC	CO CAPT D.E. STILL, MSC, USN DCS CAPT W.W. HODGE, MC, USN DAS LCDR J.W. BALDWIN, MSC, USN CH NURSE CDR E. CARSON, NC, USN
NAVREGMEDCEN, CAPM LEJEUNE, NC	CO CAPT J.L. HUGHES, MC, USN DCS CAPT R.J. SEELEY, MC, USN CH NURSE CAPT T. PROTO, NC, USN
NAVREGDENCEN, CAMP LEJEUNE, NC	CO CAPT N.K. LUTHER, DC, USN DCS CAPT T.L. WHATLEY, DC, USN DAS LCDR R.J. LINDSAY, MSC, USN
ENVIRONMENTAL AND PREV MED UNIT TWO, NORFOLK, VA	OIC CAPT H.J. CANDELA, MC, USN AO LT H.T. BROWN, MSC, USN

COMNAVMARIANAS	CAPT R.D. PRINCE, DC, USN (ADDU)
CAIRO, EGYPT	
U.S. NAVMEDRSCHUNIT #3	CO CAPT R.H. WATTEN, MC, USN AO LT D.L. WHEELER, MSC, USN SR NURSE CDR S. ROSS, NC, USN
TAIWAN	
U.S. NAVHOSP, TAIPEI	CO CDR C.M. DAY III, MC, USN SR NURSE LCDR C. ZERBATO, NC, USN
U.S. NAVMEDRSCHUNIT #2, TAIPEI	CO CDR K. SORENSEN, MC, USN AO LCDR S.A. NESS, MSC, USN
PHILIPPINES	
U.S. NAVREGMEDCEN, SUBIC BAY, ROP	CO CAPT R.A. PROULX, MC, USN DAS CDR R.M. COAN, MSC, USN CH NURSE CDR E. O'NEILL, NC, USN
U.S. NAVREGDENCEN, SUBIC BAY, ROP	CO CAPT M.M. STEVENS, DC, USN DCS CAPT J.F. LESSIG, DC, USN DAS LT N.E. CARROLL, MSC, USN
SPAIN	
U.S. NAVHOSP, ROTA	CO CAPT J.E. WILSON, MC, USN DAS CDR C.A. HARTMAN, MSC, USN CH NURSE CDR H. HOLBROOK, NC, USN
COMNAVACT, SPAIN	CAPT G.B. CROSSMIRE, DC, USN (ADDU)
HEADQUARTERS MARINE CORPS AND FLEET MARINE FORCE	
HEADQUARTERS, U.S. MARINE CORPS	CAPT G.E. GRIFFIN III, MC, USN CAPT F.R. RULIFFSON, DC, USN AO CDR G.S. HARRIS, MSC, USN
HEADQUARTERS, FMF ATLANTIC	CAPT R.R. PALUMBO, MC, USN FORDO CAPT R.S. DAVISON, DC, USN AO LCDR R.F. COXE, MSC, USN
SECOND MARINE DIVISION SURGEON	CAPT R.M. LEHMAN, MC, USN
SECOND FORCE SERVICE SUPPORT GROUP	SECOND DENCO CAPT R.A. GASTON, DC, USN
SECOND FORCE SERVICE SUPPORT GROUP	22ND DENCO FORTRPS CAPT J.S. KITZMILLER, DC, USN AO LCDR M.T. MEANEY, MSC, USN
SECOND MARINE AIRCRAFT WING	CAPT E.L. GEHRY, MC, USN
SECOND FORCE SERVICE SUPPORT GROUP	12TH DENCO CAPT D.T. FENNER, JR., DC, USN AO LT J.L. JOHNSON, MSC, USN
HEADQUARTERS, FMF PACIFIC	CAPT R.W. JONES, MC, USN FORDO CAPT P.C. ALEXANDER, DC, USN AP CAPT L.W. GAY, MSC, USN
FIRST MARINE DIVISION	CDR R.C. HODGES, MSC, USN
FIRST FORCE SERVICE SUPPORT GROUP	FIRST DENCO CAPT B.F. KRESL, DC, USN AO LCDR J.T. LEWIS, MSC, USN
FIRST MARINE AIRCRAFT WING	CDR D.S. ANGELO, MC, USN
THIRD FORCE SERVICE SUPPORT GROUP (DETA)	11TH DENCO CAPT J.E. MILLER, DC, USN AO LT R.T. FIGURA, MSC, USN
FIRST MARINE BRIGADE	CDR M.O. ABBOTT, MC, USN 21ST DENCO CAPT L.M. MULDROW, JR., DC, USN AO LCDR W.M. MC CLANNAHAN, MSC, USN
THIRD MARINE DIVISION SURGEON	CAPT D.R. HAULER, MC, USN
THIRD FORCE SERVICE SUPPORT GROUP	THIRD DENCO CAPT R.E. CASSIDY, DC, USN AO LCDR J.J. BIELAWSKI, MSC, USN
THIRD MARINE AIRCRAFT WING	CAPT G.E. BALYEAT, MC, USN
FIRST FORCE SERVICE SUPPORT GROUP	13TH DENCO CAPT R.E. WILLIAMS, JR., DC, USN AO LCDR M. ICZKOWSKI, MSC, USN
FLDMEDSERVSCOL, CAMP PENDLETON	CO CAPT W.H. JONES, MSC, USN XO LCDR E.J. LOOS, MSC, USN
FLDMEDSERVSCOL, CAMP LEJEUNE	CO CAPT E.J. STEWARD, MSC, USN XO CDR J.M. CORRELL, MSC, USN

—This roster was prepared by BUMED Code 312.

CUT ALONG THIS LINE

NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD ..... CO RADM J.T. HORGAN, MC, USN
DCS CAPT M. NIEVES, JR., MC, USN
DAS CAPT H.P. MILLER, MSC, USN
CH NURSE CAPT H. FURMANCHIK, NC, USN

NATIONAL NAVAL DENTAL CENTER, BETHESDA, MD ..... CO CAPT S.T. ELDER, DC, USN
DCS CAPT R.D. CULLOM, DC, USN
DAS CDR M.K. LAW, MSC, USN

NAVAL HEALTH SCIENCES EDUCATION AND TRAINING COMMAND, NNMC, BETHESDA, MD ... CO RADM S. BARCHET, MC, USN
XO CAPT D.M. ALLMAN, DC, USN
AO LCDR R.E. NEWMAN, MSC, USN

NAVSCOLHELCAREADMIN, BETHESDA, MD ..... CO CAPT W.J. AUTON, JR., MSC, USN
XO CDR D.R. CRAIG, MSC, USN

NAVMEDRSCHINSTITUTE, BETHESDA, MD ..... CO CAPT W.F. MINER, MC, USN
AO CDR R.A. MORIN, MSC, USN

NAVMEDRSCHDEVCOM, BETHESDA, MD ..... CO CAPT J.D. BLOOM, MC, USN
EXEC ASST CDR W. SCHROEDER, MSC, USN

ARMED FORCES INST OF PATHOLOGY, WASHINGTON, DC ..... DIR CAPT E.C. COWART, JR., MC, USN

ARMED FORCES RADIOBIOLOGY RESEARCH INSTITUTE, BETHESDA, MD ..... DIR COL L.W.R. STROMBERG, USA
AO CAPT E.D. MATIEK, MSC, USN

NAVAL MEDICAL DATA SERVICE CENTER, BETHESDA, MD ..... CO CAPT L.E. ANGELO, MSC, USN
XO LCDR R.W. GIBSON, JR., MSC, USN

NAVHOSP, PATUXENT RIVER, MD ..... CO CDR E.R. CHRISTIAN, MSC, USN
DCS CAPT J.P. SENN, MC, USN
DAS LT M.A. BLOME, MSC, USN
CH NURSE CAPT D.H. HOOKER, NC, USN

NAVHOSP, QUANTICO, VA ..... CO CDR J.R. ERIE, MSC, USN
DCS CAPT J.A. OLSEN, MC, USN
DAS LCDR D.D. WILSON, MSC, USN
CH NURSE CDR M.F. HALL, NC, USN

ITALY

U.S. NAVREGMEDCEN, NAPLES ..... CO CAPT N.W. COOLEY, MC, USN
DCS CAPT J.V. SHARP, MC, USN
DAS CDR J.A. BOYLE, MSC, USN
CH NURSE CAPT C. SHEA, NC, USN

U.S. NAVREGDENCEN, NAPLES ..... CO CAPT J.A. MC KINNON, DC, USN
DCS CAPT J.T. JANUS, DC, USN
DAS CDR P.T. RAY, MSC, USN

U.S. NAVAL ENVIRONMENTAL AND PREV MED UNIT #7, NAPLES ..... OIC CDR J.W. POUNDSTONE, MC, USN
AO LCDR D.E. ANDERSON, MSC, USN

JAPAN

U.S. NAVREGMEDCEN, YOKOSUKA ..... CO CAPT B.L. JOHNSON, MC, USN
DCS CDR J.P. SMYTH, MC, USN
DAS LCDR T.E. THOMAS, MSC, USN
CH NURSE CAPT D. CORNELIUS, NC, USN

U.S. NAVREGDENCEN, YOKOSUKA ..... CO CAPT E.T. WITTE, DC, USN
DCS CAPT R.E. HOWE, DC, USN
DAS LCDR E.C. PIERSOL, MSC, USN

U.S. NAVREGMEDCEN, OKINAWA ..... CO CAPT C.S. LAMBDIN, MSC, USN
DAS CDR C. MOORE, MSC, USN
CH NURSE CAPT M. CONLEY, NC, USN

MARIANA ISLANDS

U.S. NAVREGMEDCEN, GUAM ..... CO CAPT M.C. CARVER, MC, USN
DCS CAPT R.G. SABLAN, MC, USN
DAS LCDR K.L. LASHLEY, MSC, USN
CH NURSE CDR F. FRAZIER, NC, USN

U.S. NAVREGDENCEN, GUAM ..... CO CAPT R.D. PRINCE, DC, USN
DCS CAPT H.C. DEATON, DC, USN
DAS LCDR O.H. GRISHAM, MSC, USN

FOLD

SIXTH NAVAL DISTRICT ..... DMO CAPT I.J. WOODSTEIN, MC, USN (ADDU)
DDO CAPT R.G. GRANGER, DC, USN (ADDU)
AO LCDR R.K. GREEN, MSC, USN (ADDU)

NAVREGMEDCEN, CHARLESTON, SC ..... CO CAPT I.J. WOODSTEIN, MC, USN
DCS CAPT R.E. TOBEY, MC, USN
DAS CDR G.M. ELLIS, MSC, USN
CH NURSE CAPT R. PAMPUSH, NC, USN

NAVREGDENCEN, CHARLESTON, SC ..... CO CAPT R.G. GRANGER, DC, USN
DCS CAPT T.M. ALLENSWORTH, JR., DC, USN
DAS LT D.C. DUNKLEMAN, MSC, USN

NAVAL BASE, CHARLESTON, SC ..... CAPT R.G. GRANGER, DC, USN (ADDU)

NAVHOSP, BEAUFORT, SC ..... CO CAPT D.C. GOOD, MC, USN
DCS CAPT W.R. MULLINS, MC, USN
DAS CDR W. BLANKENSHIP, MSC, USN
CH NURSE CAPT B. SLATER, NC, USN

NAVREGDENCEN, PARRIS ISLAND, SC ..... CO CAPT H.J. SAZIMA, JR., DC, USN
DCS CAPT A. HERR, DC, USN
DAS LCDR L.R. MAASSEN, MSC, USN

NAVREGMEDCEN, JACKSONVILLE, FL ..... CO CAPT W.J. MC DERMONT, JR., MC, USN
DCS CAPT N.R. RAFFAELLY, MC, USN
DAS CAPT L.J. SCHAFFNER, MSC, USN
CH NURSE CAPT M.J. WALKER, NC, USN

NAVREGDENCEN, JACKSONVILLE, FL ..... CO CAPT E.E. MC DONALD, JR., DC, USN
DCS CAPT E.H. PLUMP, DC, USN
DAS CDR R.L. WENTWORTH, MSC, USN

NAVHOSP, KEY WEST, FL ..... CO CAPT P.F. WELLS II, MC, USN
DAS LCDR F.D.R. FISHER, MSC, USN
CH NURSE CAPT D. DUNN, NC, USN

NAVREGMEDCEN, MEMPHIS, MILLINGTON, TN .... CO CAPT C.W. BRAMLETT, MC, USN
DCS CAPT G.C. BINGHAM, MC, USN
DAS CDR B.L. STEPHENS, MSC, USN
CH NURSE CAPT M. MAYNARD, NC, USN

NAVREGMEDCEN, ORLANDO, FL ..... CO CAPT J.A. ZIMBLE, MC, USN
DCS CAPT W.A. SCHEFSTAD, MC, USN
DAS CDR L.H. TURBEVILLE, MSC, USN
CH NURSE CAPT J.M. REDGATE, NC, USN

NAVREGDENCEN, ORLANDO, FL ..... CO H.C. PUND, JR., DC, USN
DCS CAPT H.S. SAMUELS, DC, USN
DAS LCDR P.N. ACKLEY, MSC, USN

NAVAEROSPREGMEDCEN, PENSACOLA, FL ..... CO RADM R.L. BAKER, MC, USN
DCS CAPT N.D. BROUSSARD, MC, USN
DAS CAPT S.D. BARKER, MSC, USN
CH NURSE CAPT K. WILSON, NC, USN

NAVREGDENCEN, PENSACOLA, FL ..... CO CAPT T.W. MC KEAN, DC, USN
DCS CAPT S.E. PEPEK, DC, USN
DAS LCDR P.R. COWART, MSC, USN

NAVAEROMEDRSCHLAB, PENSACOLA, FL ..... CO CAPT R.E. MITCHEL, MC, USN

NAVAEROSPACEMEDINST, PENSACOLA, FL ..... CO CAPT H.S. TROSTLE, MC, USN
XO CAPT D.J. BRIDEAU, MSC, USN

DISEASE VECTOR ECOLOGY AND CONTROL CENTER, JACKSONVILLE, FL ..... OIC LCDR L.L. SHOLDT, MSC, USN
AO LT B.R. FORO, MSC, USN

EIGHTH NAVAL DISTRICT ..... DMO CAPT P.D. COOPER, MC, USN (ADDU)
DDO CAPT A.J. BARTOSH, DC, USN (ADDU)

NAVREGMEDCEN, CORPUS CHRISTI, TX ..... CO CAPT T.J. TRUMBLE, MC, USN
DCS CAPT D.W. PEACE, JR., MC, USN
DAS CDR W.A. GODFREY, JR., MSC, USN
CH NURSE CAPT M. DONOGHUE, NC, USN

NAVREGMEDCEN, NEW ORLEANS, LA ..... CO CAPT P.D. COOPER, MC, USN
DAS CAPT J.L. GRAVES, MSC, USN
CH NURSE CAPT B. NAGY, NC, USN

NINTH NAVAL DISTRICT	DMO CAPT M.J. VALASKE, MC, USN (ADDU) DIR DENACTYS CAPT C.J. MC LEOD, DC, USN (ADDU) AO ENS T.P. CORMIER, MSC, USN
NAVREGMEDCEN, GREAT LAKES, IL	CO CAPT M.J. VALASKE, MC, USN DCS CAPT L.R. FOUT, MC, USN DAS LCDR R.A. PAYTON, MSC, USN CH NURSE CAPT E.M. PFEFFER, NC, USN
NAVREGDENCEN, GREAT LAKES, IL	CO CAPT C.J. MC LEOD, DC, USN DCS CAPT H.B. MC WHORTER, DC, USN DAS CDR P.J. COLLIER, MSC, USN
NAVDENTALRSCHINSTITUTE, NB, GREAT LAKES, IL	CO CAPT M.R. WIRTHLIN, JR., DC, USN
NAVHOSPCORPSCOL, GREAT LAKES, IL	CO CDR C.J. THEISEN, JR., MSC, USN XO LCDR F. BRIAND, MSC, USN SR NURSE CDR P. FLEURY, NC, USN
NAVENVIRHLTHCEN, CINCINNATI, OH	OIC CAPT T.N. MARKHAM, MC, USN MED ADM OFF LT F.C. HARDY, MSC, USN
TENTH NAVAL DISTRICT	DMO CAPT P.C. GREGG, MC, USN (ADDU) DDO CAPT D.E. BARLOW, DC, USN (ADDU)
NAVHOSP, GUANTANAMO BAY	CO CAPT R.P. BISHOP, MC, USN DAS LCDR R. RELINSKI, MSC, USN CH NURSE CDR F. DAVISON, NC, USN
COMNAVB GUANTANAMO BAY	DO CAPT J.R. BOHACEK, DC, USN (ADDU)
NAVHOSP, ROOSEVELT ROADS, PR	CO CAPT P.C. GREGG, MC, USN DAS CDR H.B. LEVANDOWSKI, JR., MSC, USN CH NURSE CAPT C. FINN, NC, USN
NAVREGDENCEN, ROOSEVELT ROADS, PR	CO CAPT D.E. BARLOW, DC, USN DCS CAPT R.A. MURPHY, DC, USN DAS LT W.M. MILLS, MSC, USN
ELEVENTH NAVAL DISTRICT	DMO RADM J.W. COX, MC, USN (ADDU) DIRDENACTYS RADM W.L. DARNALL, JR., DC, USN (ADDU) AO CDR J.B. KNIGHT, MSC, USN (ADDU)
NAVREGMEDCEN, CAMP PENDLETON, CA	CO CAPT C.H. LOWERY, MC, USN DCS CAPT D. REID, MC, USN DAS CAPT F.C. PITTINGTON, MSC, USN CH NURSE CAPT P. PORTZ, NC, USN
NAVREGDENCEN, CAMP PENDLETON, CA	CO CAPT W.E. SUGG, JR., DC, USN DCS CAPT J.D. MAHONEY, DC, USN DAS LCDR J.D. GALBREATH, MSC, USN
NAVREGMEDCEN, LONG BEACH, CA	CO CAPT Q.E. CREWS, MC, USN DCS CAPT E.E. FREEMAN, MC, USN DAS LCDR D.N. BENANDER, MSC, USN CH NURSE CAPT A. WILLIAMS, NC, USN
NAVREGDENCEN, LONG BEACH, CA	CO CAPT H.W. HODSON, DC, USN DCS CAPT F.A. PAPERA, DC, USN DAS LT G.R. HARRINGTON, MSC, USN
NAVAL SCHOOL OF HEALTH SCIENCES, SAN DIEGO, CA	CO CAPT W.E. MC CONVILLE, MSC, USN XO CDR G.E. HAMMETT, MSC, USN SR NURSE CAPT M. PERLOW, NC, USN
ENVIRONMENTAL AND PREV MED UNIT #5, SAN DIEGO, CA	OIC CAPT S.J. KENDRA, MC, USN AO LT D.R. GRAY, MSC, USN
NAVHOSP, PORT HUENEME, CA	CO CDR J.E. JOHNS, MSC, USN DCS CAPT T.E. CARSON, MC, USN DAS LCDR S.J. PROFITA, MSC, USN CH NURSE CDR C. BELEZOS, NC, USN
NAVREGMEDCEN, SAN DIEGO, CA	CO RADM J.W. COX, MC, USN DCS CAPT J.S. CASSELLS, MC, USN DAS CAPT E.N. BUCKLEY, MSC, USN CH NURSE CAPT F. SHEA, NC, USN

NAVREGDENCEN, SAN DIEGO, CA	CO RADM W.L. DARNALL, JR., DC, USN DCS CAPT E.J. HEINKEL, JR., DC, USN DAS CDR W.E. GROCE, MSC, USN
NAVHLTHRSCHCEN, SAN DIEGO, CA	CO CAPT R.H. RAHE, MC, USN XO LCDR W. FERRIS, MSC, USN
COMNAVBASE, LOS ANGELES	DO CAPT H.W. HODSON, DC, USN (ADDU)
TWELFTH NAVAL DISTRICT	DMO RADM W.M. LONERGAN, MC, USN (ADDU)
NAVREGMEDCEN, OAKLAND, CA	CO RADM W.M. LONERGAN, MC, USN DCS CAPT L.U. PULICICCHIO, MC, USN DAS CAPT H.H. SOWERS, MSC, USN CH NURSE CAPT L. PETERSON, NC, USN
COMPATWINGSPAC MFT	DO CAPT W.C. SULLIVAN, DC, USN (ADDU)
NAVHOSP, LEMOORE, CA	CO CAPT J.J. PALMER, MSC, USN DCS CAPT E.L. BINGHAM, MC, USN DAS CDR F. TEAGUE, MSC, USN CH NURSE CDR J. BARNES, NC, USN
NAVREGDENCEN, SAN FRANCISCO, CA	CO CAPT J.E. HYDE, DC, USN DCS CAPT R.P. MORSE, DC, USN DAS CDR G. RAMIREZ, MSC, USN
NAVDISVECTECOLCONCEN, ALAMEDA, CA	OIC LCDR R.V. PETERSON, MSC, USN AO LT T.W. WILDER, MSC, USN
NAVBIOSCILAB, OAKLAND, CA	CO CAPT J.F. PRIBNOW, MSC, USN AO LTJG J.D. FORD, MSC, USNR
THIRTEENTH NAVAL DISTRICT	DMO CAPT R.C. ELLIOTT, MC, USN (ADDU) DDO CAPT R.G. THOMPSON, DC, USN (ADDU) AO LCDR K.W. SHAFFER, MSC, USN (ADDU)
NAVREGMEDCEN, BREMERTON, WA	CO CAPT R.C. ELLIOTT, MC, USN DAS CDR D.D. PALMER, MSC, USN CH NURSE CAPT M.G. STEWART, NC, USN
NAVREGDENCEN, BREMERTON, WA	CO CAPT R.G. THOMPSON, DC, USN DCS CAPT J.F. SCOTT, DC, USN DAS LT C.E. LAND, MSC, USN
NAVHOSP, WHIDBEY ISLAND, OAK HARBOR, WA	CO CDR G.W. BALDAUF, MSC, USN DCS CAPT D.W. COWHERD, MC, USN DAS CDR P.O. DILLEY, MSC, USN CH NURSE CDR K. KENDALL, NC, USN
NAVCLINIC, NSA, SEATTLE, WA	CO CAPT R.L. SURFACE, MSC, USN XO LCDR K.W. SHAFFER, MSC, USN SR NURSE LCDR V.E. BOYCE, NC, USN
FOURTEENTH NAVAL DISTRICT	DMO CAPT A.L. SOLGAARD, MC, USN (ADDU) DDO CAPT N.D. WILKIE, DC, USN (ADDU) AO CDR D.R. FERGUSON, MSC, USN (ADDU)
NAVREGMEDCLINIC, PEARL HARBOR, HI	CO CAPT A.L. SOLGAARD, MC, USN DAS CDR D.R. FERGUSON, MSC, USN SR NURSE CAPT A. GOMES, NC, USN
NAVREGDENCEN, PEARL HARBOR, HI	CO CAPT N.D. WILKIE, DC, USN DCS CAPT A.D. LOIZEAUX, DC, USN DAS LCDR J.D. DELAUGHTER, MSC, USN
NAVMEDADMUNIT TRIPLER ARMY HOSP, HONOLULU, HI	OIC
ENVIRONMENTAL AND PREVENTIVE MEDICINE UNIT #6, PEARL HARBOR, HI	OIC CAPT T.R. BYRD, MC, USN AO LT J.M. CONSENZA, MSC, USN
NAVAL DISTRICT, WASHINGTON, DC	DMO RADM J.T. HORGAN, MC, USN (ADDU) DDO CAPT S.T. ELDER, DC, USN (ADDU)
NAVHOSP, ANNAPOLIS, MD	CO CAPT J.D. PRUITT, MSC, USN DCS CAPT W.J. WAGNER, MC, USN DAS LCDR L.L. MOORE, MSC, USN CH NURSE CAPT L. NICKERSON, NC, USN

Not content simply with caring for inpatients, nurses and hospital corpsmen at NRMC San Diego are volunteering off-duty time to teach cardiopulmonary resuscitation techniques to crewmembers of afloat commands in the area.

The CPR presentation is offered in conjunction with the American Heart Association and leads to certification by that organization. To date, the San Diego project has resulted in certification of more than 200 crewmembers.

In the photo, LCDR **Elizabeth D. Kunc** (NC), teaches CPR basics to crewmembers of the USS *Blue Ridge* (LCC-19).

When LT **Jerry W. Rose** (MC) completed his internship at NRMC Oakland in June, he got a bonus: the wings of a Navy flight surgeon.

Rose had enrolled in the six-month flight surgeon program (which includes six weeks of flight training) as an elective during his senior year of medical school at the University of Washington.

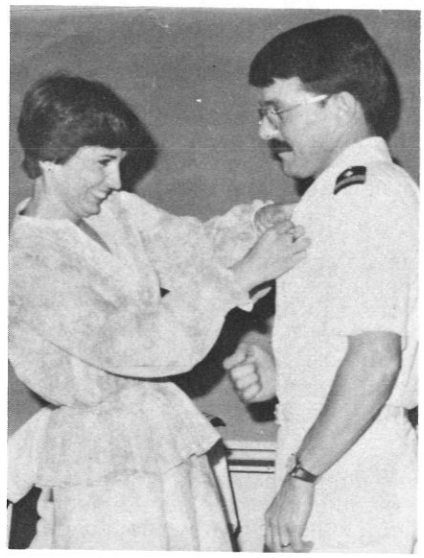
Normally, the program is open only to physicians who have already completed a one-year internship. According to records at the Naval Aerospace Medical Institute, Pensacola, Rose is the first medical student to complete the flight-surgeon syllabus.

When he finished flight school in December 1976, Rose was presented a certificate and the promise that he would be designated a naval flight surgeon when he completed the program's usual prerequisites.

A year and a half of waiting paid off on June 30, when Rose's wife, Barbara, pinned on his wings. Shortly thereafter, Rose was on his way to Okinawa, where he will be flight surgeon for the First Marine Air Wing.

In the case of this giant tooth, all that glitters is indeed gold: it represents the response of the Naval Regional Dental Center, Camp Pendleton, Calif., to this year's Navy Relief Fund Drive.

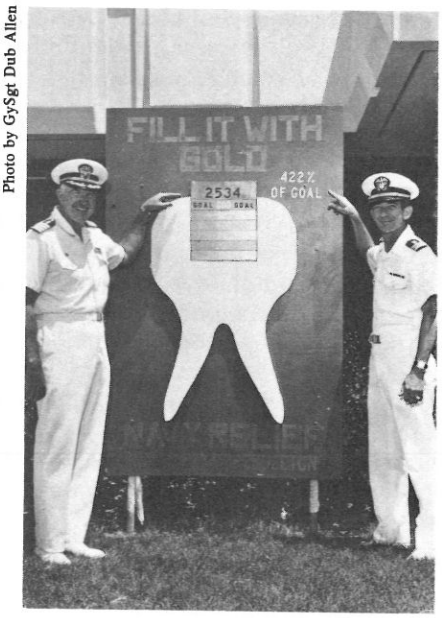
CAPT **B. C. Sharp** (DC), commanding officer, and LCDR **J. D. Galbreath** (MSC) point to the achievement: $2,534 pledged for Navy relief—more than four times the assigned $600 goal.



Rose: On the wing

Kunc: CPR training for seagoers

Photo by GySgt Dub Allen



Sharp & Galbreath: Goldfingers

Bezoar: An Unusual Complication of Surgery for Dumping Syndrome

LCDR Gerald S. Weinstein, MC, USNR

Interposition of a reversed segment of jejunum between the gastric remnant and the duodenum has been shown to be an effective treatment for dumping syndrome. This article describes a previously unreported complication of this procedure: development of a phytobezoar.

Case presentation

F.B., a 38-year-old white male with a 20-year history of duodenal ulcer disease, had undergone truncal vagotomy and pyloroplasty in 1974.

Immediately following that operation, the patient developed severe dumping syndrome accompanied by hypoglycemia. Despite antidumping diets, he had episodes of flushing, tachycardia, diarrhea, and prostration six to ten times per day. During these episodes, his blood glucose levels were found to be between 20 and 32 mg/100 ml.

On 10 Mar 1977, the patient underwent antrectomy and reversed jejunal segment interposition, as described by Herrington and Sawyers (*1,2*). A 10-cm segment of jejunum was interposed between the gastric remnant and the duodenum.

The patient's postoperative course was complicated by an episode of sepsis, thought to be due to an anastomotic leak. He responded dramatically to antibiotics and was discharged on the 25th postoperative day. The dumping syndrome and hypoglycemia were completely abolished by the operation, and the postoperative glucose tolerance test was normal.

Subsequently, the patient developed early satiety and delayed gastric emptying. Fiberoptic gastroscopy showed narrowing of the gastrojejunal anastomosis. It was felt that the patient had developed a stricture secondary to an anastomotic leak.

Revision of the anastomosis and Stamm gastrostomy were performed on 15 June 1977. The patient recovered well from this procedure and remained asymptomatic for approximately two months, when he became incapacitated by manometry-proved diffuse esophageal spasm, refractory to conservative management. On 6 Sept 1977, he underwent extended esophagomyotomy. Fiberoptic gastroscopy at that time was normal.

Several weeks following this third procedure, the patient complained of post-thoracotomy pain and a "ball-like" feeling in his abdominal wall. Intercostal nerve block relieved the post-thoracotomy pain, but the "ball-like" feeling remained.

On 21 Nov 1977, the patient was readmitted to the hospital with severe abdominal pain. Chest and abdominal X-rays showed the presence of a large food mass in a greatly distended gastric remnant (Figure 1).

A gastrostomy tube was reinserted under local anesthesia, and a solution of commercial meat tenderizer (one teaspoon in 30 ml of water) was instilled through the tube every four hours.

Within eight hours, the mass had decreased in size, and large pieces of undigested food material could be extracted from the gastrostomy tube.

By the next day, the food mass was approximately one half its initial size (Figure 2). This decrease in size was associated with relief of the "ball-like" feeling.

The food mass was gone by the fifth day (Figure 3). An upper G.I. series performed prior to the patient's discharge showed no evidence of obstruction or excessively delayed gastric emptying.

From the Department of Surgery, NRMC Newport, R.I. 02840.

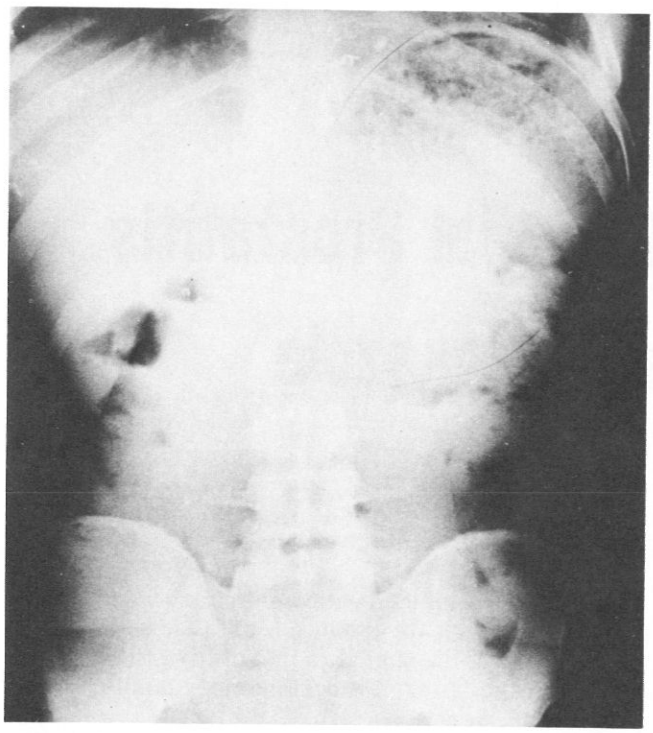


FIGURE 1. A large mass of undigested food greatly distends the gastric remnant.

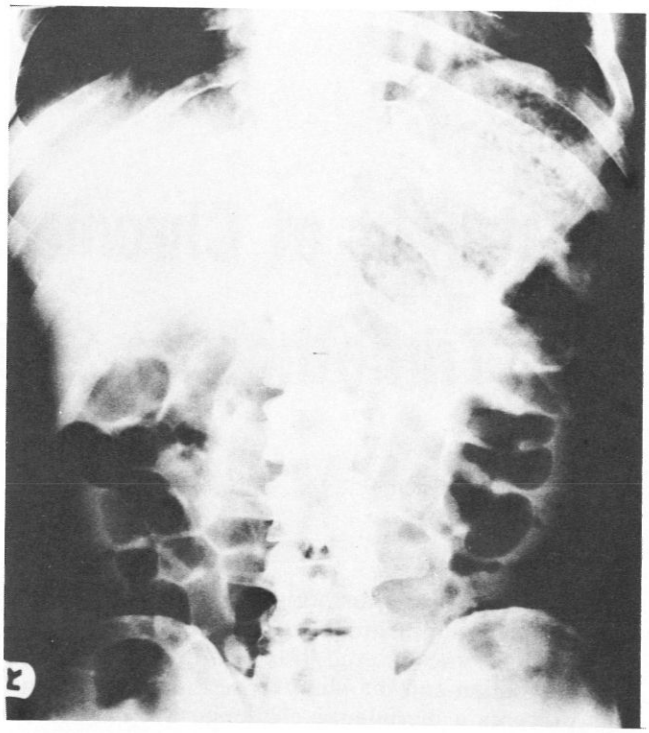


FIGURE 2. After one day of therapy with commercial meat tenderizer, the food mass is reduced to approximately one half its initial size.

On careful questioning, the patient recalled eating as many as six to eight nectarines per day for four to six weeks following his esophagomyotomy.

Discussion

The purpose of reversed jejunal segment interposition for dumping syndrome is, of course, to slow gastric emptying. Although it may be expected that such a situation may provide the setting for formation of a phytobezoar, such an occurrence has not been reported.

Enzymatic treatment with commercial meat tenderizer, which contains papain, was quite successful and demonstrates that nonoperative therapy is possible.

Patients of this sort should be cautioned against eating large amounts of fleshy fruits or other high-residue foods.

References

1. Herrington JL, Sawyers JL: A new operation for the dumping syndrome and post-vagotomy diarrhea. Ann Surg 175:790, 1972.
2. Sawyers JL, Herrington JL: Superiority of antiperistaltic jejunal segments in management of severe dumping syndrome. Ann Surg 178:311, 1973.

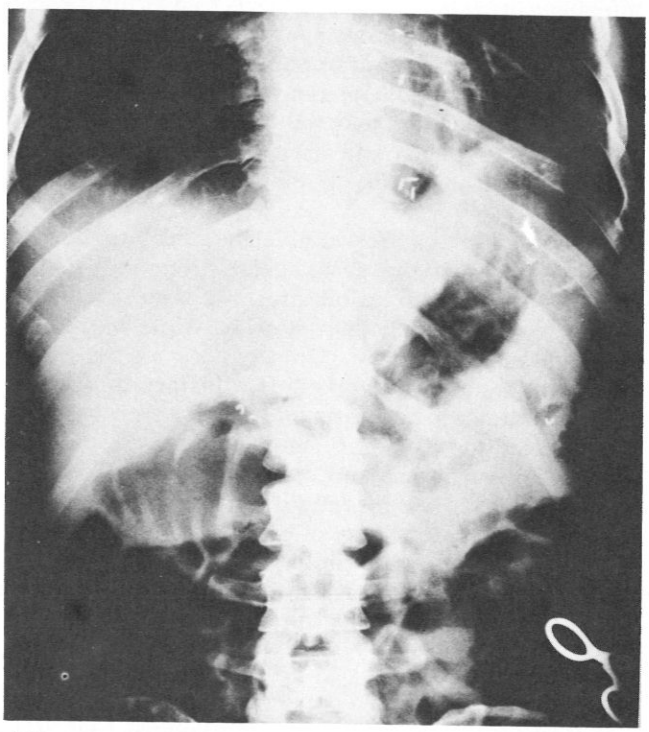


FIGURE 3. Five days after patient's admission, food mass is entirely gone. Note the presence of the gastrostomy tube.

Treatment of Chronic Bacterial Prostatitis with Trimethoprim-Sulfamethoxazole

LCDR Donald F. Lynch, Jr., MC, USN

Chronic bacterial prostatitis is the most common cause of relapsing urinary tract infection in the adult male (*1*). It is encountered in both the younger active-duty population and the older retired populations, and thus presents a therapeutic challenge not only to the hospital-based urologist, but also to the dispensary or ship-based general medical officer.

Chronic bacterial prostatitis is always caused by an infectious organism, although this is frequently difficult to document. The disorder is characterized by variable urethral, perineal, or suprapubic pain; mild dysuria; decreased stream caliber; and dribbling. Mild discomfort with ejaculation may be present. Urethral discharge—usually clear and often scanty—is present and is often most noticeable in the morning. There is no fever.

Physical findings are variable, but mild tenderness and bogginess of the prostate are frequently noted. There is always expressible prostatic secretion, which usually contains more than 40 to 60 white blood cells per high-power field.

An additional characteristic is a history of multiple previous attempts at treatment, usually with transient improvement or temporary cure, but with eventual recurrence of symptoms and findings.

Trimethoprim is a recently developed antibiotic that acts against a wide variety of gram-negative and gram-positive organisms by inhibiting folate synthesis. It has been shown to have an affinity for prostatic tissue, and high tissue concentrations can be obtained. When trimethoprim is combined with a sulfonamide, the activities of both drugs are enhanced. Because sulfamethoxazole has a half-life similar to that of trimethoprim, it is used with the latter in a commercially available drug preparation, Septra.

Preliminary indications that trimethoprim-sulfamethoxazole had been effective in the treatment of chronic bacterial prostatitis prompted an evaluation of this drug in our clinic population.

Materials and methods

Thirty-three patients, ranging in age from 23 to 72, were treated for chronic bacterial prostatitis between August 1975 and February 1977. All had histories of unsuccessful previous treatment for this disorder.

Two methods of diagnosis were employed. Twenty-three patients were diagnosed on the basis of positive cultures of expressed prostatic secretions (EPS) or post-

TABLE 1. Means of Diagnosis/Organism Cultured

Source	No. of patients	Organism cultured
TRIMETHOPRIM-SULFAMETHOXAZOLE GROUP		
VB3	11	(E. coli- 11)
EPS	5	(E. coli- 4, Klebsiella- 1)
"CP"	8	—
TETRACYCLINE GROUP		
VB3	5	(E. coli- 5)
EPS	2	(E. coli- 2)
"CP"	2	—

From the Department of Urology, NRMC San Diego, Calif. 92134.
Presented at the 25th Kimbrough Urological Seminar, Denver, Colo., 7-11 Nov 1977.

prostatic-massage urines (VB3), as described by Meares and Stamey (*2*). Ten additional patients were diagnosed on the basis of irritative and obstructive symptoms, prostate examination, urethral discharge, and examination of the expressed prostatic secretions, as modified after Chesley and Dow (*3*). This latter method was referred to as the "classic picture" ("CP") diagnosis, and was an attempt to reproduce diagnostic conditions prevailing at small facilities lacking the bacteriologic equipment required to prove the diagnosis by culture.

"Cure" was defined as resolution of symptoms, clearing of urethral discharge and prostatic secretions, and clearing of cultures.

"Improvement" was defined as clearing of cultures, with partial resolution of symptoms.

"Failure" was defined as no change in symptoms, or relapse to positive cultures, with recurrence of symptoms, within 6 months.

Two courses of therapy were utilized. One group of patients received trimethoprim, 160 mg, and sulfamethoxazole, 800 mg, twice daily for 30 days. A second group was treated with tetracycline, 0.5 gm, four times daily for 30 days.

Followup time ranged from 9 to 25 months. Each patient was seen at the completion of therapy and at 3 and 6 months after treatment. Most have been followed more than 12 months. VB3 cultures were obtained at the completion of treatment and at the 6-month visit.

Results

Twenty-four patients were treated with trimethoprim-sulfamethoxazole. Five additional patients were allergic to sulfa, and 4 patients presented after having tetracycline therapy initiated elsewhere. These 9 patients were treated with tetracycline. Of 23 patients with positive cultures, 22 were due to *E. Coli* and 1 to *Klebsiella*. The average colony count of the positive cultures was 10^4 colonies. The distribution of patients, by diagnosis and culture, is shown in Table 1.

The results of treatment are outlined in Table 2. Fifteen of 24 patients treated with trimethoprim-sulfamethoxazole were cured, and 3 noted improvement. Two of 9 patients treated with tetracycline were cured, with 1 noting improvement. The response of patients diagnosed on the basis of the "classic picture" was identical to that of those diagnosed by bacterial culture.

No drug reactions or other complications of treatment were observed.

TABLE 2. Results of Treatment

	Cured	Improved	Failed	Totals
TMP-SMZ	15 (63%)	3 (13%)	6 (25%)	24
TCN	2 (22%)	1 (11%)	6 (66%)	9
				33

Discussion

The diagnosis of chronic bacterial prostatitis is complicated by the variability of presenting symptoms and the difficulties inherent in obtaining bacterial cultures from the prostate. Differentiation between mild acute prostatitis, abacterial prostatitis or prostatosis, and chronic bacterial prostatitis may, at times, be impossible.

The results of other evaluations of trimethoprim-sulfamethoxazole in the treatment of chronic bacterial prostatitis are shown in Table 3. The variation in treatment periods, ranging from 28 days to 12 weeks, makes precise comparison difficult, but the results of the present study are encouraging.

The culture techniques advocated by Meares and Stamey are useful in documenting infection of the prostate (*2,4*). The bacterial cultures obtained in this study, using their techniques, are consistent with infection patterns noted by other investigators (*4,6,7*). Culture of the semen rather than of expressed prostatic secretions, while not utilized here, has been successfully employed and should receive additional evaluation (*5*).

Drach has observed that trimethoprim was more effective in curing prostatitis due to gram-negative organisms than that due to gram-positive organisms (*6*). The fact that only gram-negative organisms were cultured from patients in this study may partly explain the improved cure rate observed.

TABLE 3. Comparison with Other Studies

Study	Cure rate
Chesley and Dow (1973)	47%
Drach (1974)	33%
Meares (1975)	31%
McGuire and Lytton (1976)	33%
Present study	63%

The "classic picture" diagnosis of chronic bacterial prostatitis, while less scientific than diagnosis from bacterial cultures, is still widely used (*3,8*). The finding of white blood cells in the prostatic secretions, by itself, has been shown to be an unsatisfactory criterion for diagnosing chronic prostatitis (*9,10*). In the absence of a dependable bacteriology laboratory, microscopic examination of the prostatic secretions, combined with a careful history and physical examination, can be useful in making the decision to initiate therapy.

The mean age of the patients in the trimethoprim-sulfamethoxazole group was 38 years. Cure was achieved in 12 of 16 patients (75%) under 40 years of age. Of the 8 patients over 40, 3 (38%) were cured. More than half of the patients in Drach's study were over 40 years old (*6*). Age was not addressed by other investigators, but it is suspected that the preponderance of these patients were over 40. In older patients, the presence of prostatic calculi, benign prostatic hypertrophy, or other lower urinary tract obstruction can perpetuate infection and hamper therapy. The improved cure rate achieved in the present study is probably a reflection of the large number of younger patients treated.

Although the data presented are limited, this study suggests that the combination drug trimethoprim-sulfamethoxazole represents a major advance in the treatment of chronic bacterial prostatitis. A 30-day course of therapy can produce complete cure, especially in patients under 40, and long-term treatment with low doses may afford relief in patients for whom complete cure cannot be achieved. The results of this study imply superiority of this drug regimen over the standard tetracycline regimen that has been used for this disorder.

References

1. Meares EM: Bacterial prostatitis vs "prostatosis." JAMA 224:1372-1375, 1973.
2. Meares EM, Stamey TA: Bacterial localization patterns in bacterial prostatitis and urethritis. Invest Urol 5:492-518, 1968.
3. Chesley AE, Dow D: Use of trimethoprim-sulfamethoxazole in chronic prostatitis. Urology 2:280-282, 1973.
4. Meares EM: Prostatitis: a review. Urol Clin North Am 2:3-27, 1975.
5. McGuire EJ, Lytton B: Bacterial prostatitis: treatment with trimethoprim-sulfamethoxazole. Urology 7:499-501, 1976.
6. Drach GW: Trimethoprim-sulfamethoxazole therapy of bacterial prostatitis. J Urol 111:637-639, 1974.
7. Drach GW: Prostatitis: man's hidden infection. Urol Clin North Am 2:499-520, 1975.
8. Brannan W: Treatment of Chronic Prostatitis. Urology 5:626-631, 1975.
9. Bowers JE, Thomas GB: Clinical significance of abnormal prostatic secretions. J Urol 79:976-982, 1958.
10. Bourne CW, Frishette WA: Prostatic fluid analysis and prostatitis. J Urol 97:140-144, 1967.

Notes from the I.G., Medical

Surplus equipment. In numerous activities, equipment that has become surplus to the needs of the command is stored in various places without an active disposal program. It is recommended that commands review their procedures for disposal of equipment no longer required.

Uncollectable accounts. At some commands, uncollectable accounts for patient care have not been properly followed up. The result has been excessively high amounts in "accounts receivable." It has been determined advantageous that the Naval Investigative Service (NIS) be informed of the names of individuals with deliquent accounts, since the same individuals may possibly pass bad checks in the commissaries and exchanges or engage in other activities of an illegal nature. Therefore, we recommend that the names of individuals with past-due accounts be provided NIS for their information.

BMET and Public Works personnel. We remind commands that, prior to purchase of new equipment, BMET or Public Works personnel (or both, depending upon the type of equipment) should receive training in the operation and maintenance of this equipment.

In-service training programs. There is a need for continued emphasis on improvement of the enlisted In-Service General Military Training Programs. In the development of these programs, consideration should be given to ensuring that:

- Only outstanding and highly qualified personnel are assigned as instructors, and that equally qualified personnel are assigned as substitutes whenever the principal instructor is unavailable.
- Lesson plans be submitted to, and reviewed by, the In-Service Training Officer, Nursing Education Coordinator, or Chief of Service to which the lesson plan refers to ensure appropriateness and validity of topic.
- Local instructions on attendance and excused absences are complied with.
- The In-Service Training Officer and Nursing Education Coordinator concurrently develop, organize, and administer the program.
- Class schedules be prepared and promulated to provide sufficient lead-time notification to attendees and instructors.
- Appropriate records of in-service training be maintained to ensure required documentation of eligibility for advancement in rate.

BUMEDINST 1510.8 is the applicable instruction.

—RADM Melvin Museles, MC, USN

ASBESTOS SURVEILLANCE . . . VADM Willard P. Arentzen (MC), Navy Surgeon General, has announced establishment of an expanded medical surveillance program for all Navy uniformed and civilian personnel potentially exposed to airborne asbestos.

In CY 1977, an estimated 14,000 Navy personnel were examined to meet requirements of DOD Occupational Safety and Health Regulations. It is estimated that as many as 70,000 civilian and 150,000 active-duty personnel will be included in the new program, which has been expanded to cover all present Navy civilian and uniformed personnel who may have had past occupational exposure to airborne asbestos, or who are potentially exposed to low levels of airborne asbestos.

Implementation of the program will include hiring of 55 additional Medical Department personnel for Navy medical care facilities and expenditure of approximately $1.6 million in the first year.

In phase one of the program, all current uniformed and civilian employees who may ever have been exposed to asbestos will be identified by the completion of a questionnaire. In phase two, those who have been potentially exposed will be interviewed and receive a medical examination, including recording of their occupational and respiratory history, physical examination of the chest, chest X-ray, and pulmonary function tests.

Personnel whose medical examinations show evidence of lung change compatible with asbestos exposure will have their medical records flagged for surveillance with an annual medical examination for the duration of their federal service. Those whose questionnaires and interviews indicate a history of asbestos exposure, but who show no present evidence of asbestos-related physical change, will be scheduled for future medical examinations at least once every five years. Because of the unique high-risk relationship between smoking and exposure to airborne asbestos, all regular smokers with an exposure history, as determined by the survey, will be placed in the medical surveillance program and receive annual examinations.

The Navy is adopting a "medical surveillance action level" that will require medical examination for all individuals who, in the course of employment, are required to enter or work, "on a regular basis," in areas containing airborne asbestos concentration of 0.5 fibers greater than 5 micrometers in length, per cubic centimeter of air, as determined by phased contrast microscopy. This means that more Navy people will be monitored than would ordinarily be included under the current standards for asbestos-exposed workers.

The new standards define "on a regular basis" as exposure for 15 days in any calendar quarter, or 45 days per year. Additionally, individuals exposed above a "ceiling limit" of 10 fibers per cc of air at any time will be placed in the medical surveillance program.

PAP SMEAR PROBLEM . . . Women who had a pap smear at an Air Force medical facility between June and September 1977 and have not been subsequently reexamined should contact the facility immediately to determine whether a reexamination is necessary.

The Air Force recently discovered that some pap smears taken at 94 Air Force facilities throughout the world may have been misclassified by an Air Force contractor.

Since 1 July 1972, the Air Force has used the services of this contractor periodically. As an extra precaution, women who had pap smears at an Air Force facility between 1 July 1972 and May 1977—and have not had one other than at an Air Force installation since then—should consult a doctor to determine if a reexamination is required.

CORRECTION . . . The Navy Editor Service recently listed the Navy Physician's Assistant Program, Navy Enlisted Nursing Education Program, and Navy Enlisted Dietetic Education Program as "paths to a commission." This information was erroneous and will be corrected by NES; nonetheless, it may crop up in current Navy publications.

The programs referred to are no longer in existence. The Physician's Assistant Program is being revised and will be reinstituted in the coming year. Eligibility and application procedures are being finalized at this time.

AUDIT TIPS . . . The following discrepancies were noted on a recently completed audit:

- Establish separate bulk storage areas for Navy standard stock and commercial distributor provisions items.
- Revise current procedures for custody and handling of keys to comply with the guidelines established by NAVSUP P-486, para. 1056.
- Ensure that shelf-life items are identified, controlled, and inspected in accordance with NAVSUP Manual para. 21108-24031 and NAVMEDMATSUPPCOM-FMSO Instruction 4000.1.

☆U.S.GOVERNMENT PRINTING OFFICE: 1978--261-379/7

U.S. NAVAL PUBLICATIONS and FORMS CENTER
ATTN: CODE 306
5801 Tabor Avenue
Philadelphia, Pa. 19120
Official Business

POSTAGE AND FEES PAID
DEPARTMENT OF THE NAVY
DoD-316

CONTROLLED CIRCULATION RATE

SUBSCRIPTIONS AVAILABLE

U.S. NAVY MEDICINE is now available by subscription. Supporters of Navy medicine who are not eligible for free distribution, or who want their copy sent to their home address may order a personal subscription through the U.S. Government Printing Office. Subscription rates are $11 per year (12 issues) to addresses within the U.S., and $14 per year to foreign addresses.

Enter my subscription to U.S. NAVY MEDICINE.—$11.00 domestic mailing—$14.00 foreign mailing. (Subscription rates include postage and handling costs. Make checks payable to Superintendent of Documents.)

Send Subscription to:

NAME—FIRST, LAST

COMPANY NAME OR ADDITIONAL ADDRESS LINE

STREET ADDRESS

CITY | STATE | ZIP CODE

PLEASE PRINT

MAIL SUBSCRIPTION FORM TO:
Assistant Public Printer
(Superintendent of Documents)
Government Printing Office
Washington, DC 20402

U.S. NAVY MEDICINE